VA MISSION ACT:

UPDATE ON THE IMPLEMENTATION OF THE COMMUNITY CARE NETWORK

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WEDNESDAY, FEBRUARY 5, 2020

United States Senate,

Committee on Veterans' Affairs,

Washington, D.C.

The Committee met, pursuant to notice, at 9:31 a.m., in Room 418, Russell Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Rounds, Tillis, Sullivan, Blackburn, Loeffler, Tester, Murray, Brown, Blumenthal, Hirono, Manchin, and Sinema.

OPENING STATEMENT OF CHAIRMAN MORAN

Chairman Moran. The Committee will come to order. Good morning, everyone. For our first hearing we are taking on the topic of the implementation of the MISSION Act, something that this Committee and Congress has spent a lot of time on over a long period of time on community Care. And I thank you, Dr. Stone, for you and your team joining us on today's first panel. I also thank the witnesses on our second panel for being here. I look forward to hearing their perspective as well.

I certainly believe that the delivery of quality and timely health care to veterans has been a top priority for

this Committee and for me. When our servicemembers leave the military it is our duty to make sure they receive the care that they have earned.

Congress enacted the MISSION Act to transform VA health care into an innovation and responsive 21st century health care system capable of addressing the challenges with veterans today. And I think there is an important point to be made, that the MISSION Act, while we talk about it, and I just did a community care, care of the community, it is much more than just that.

Our hearing today will focus on the efforts of the VA to deploy community care networks. The network is central to the MISSION's Community Care Program.

When I was a Congressman I represented a congressional district size about the same as Illinois. No VA hospital in that congressional district, and so I bring a perspective of distance and travel time to my job in trying to care for veterans. So, in part, I always remain interested in how we care for veterans who live long distances from the VA's presence and how we can expand that presence to them.

The VA recently completed Region 1 deployment of the network, and the first four regions, representing the lower 48 states, are scheduled to be completed by the end of this year. The Committee has concerns about how the VA is building out the network and its ability to meet veteran

demand.

Under MISSION's expanded eligibility requirements, the number of patients seeking outside care is supposed to increase from 648,000 to 3.7 million. A recent VA OIG report predicts wait times could worsen once MISSION is in full effect. This is in addition to reports that the VA is still struggling with scheduling delays and paying community providers on time. We want to make sure this does not occur and look forward to working with you, Dr. Stone, and others at the VA, to ensure that.

We must take the opportunity to learn what happens in Region 1 and have an honest conversation about the difficulties that could threaten the network well before it is fully deployed. We owe it to the veterans to get MISSION right the very first time.

I now turn to my friend and Ranking Member, the Senator from Montana, Senator Tester, for his opening statement.

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. Thank you, Chairman Moran, and I want to thank you for starting this meeting on time. I appreciate that very, very much. And I want to thank the three doctors for being here, especially you, Dr. Stone. I appreciate the meeting we had last week and the conversation you had with my staff and myself.

In the 90 days following implementation of the new

Veterans Community Care Program there were nearly 258,000 more referrals for the private sector than in the preceding 90 days. More concerning, there are 283,000 fewer referrals for appointments in the VA during that same period. So referrals for community care went up significantly and referrals for the VA went down significantly.

I am concerned and I hope you are as well, and I need to understand what has happened, and if it is still going on, and if that is the intent. Congress did not create the new Community Care Program to simply supplant VA care with the private sector care, particularly when it takes less time for veterans to schedule appointments to be seen in VA facilities. It was set up to supplement VA care, in cases where the veteran, who is the driver of the situation, wanted to go into the community, for whatever reason that might be.

If the VA is connecting veterans more quickly, why are so many veterans getting their care in the private sector. I am concerned that 43,000 vacancies in the VHA are one of the chief reasons, and we talked about that, but I remain frustrated that VHA is not making effective and aggressive use of the authorities Congress has provided to recruit and retain providers and support staff, particularly in areas that are rural.

I am also concerned by reports that the decision

support tool that was supposed to assist veterans and their providers in making decisions on where to get care is being underutilized because providers are choosing not to use it. My understanding is that the purpose of the DST was to review the criteria prescribed in the MISSION Act and determine whether a veteran is eligible and best served by utilizing private sector care, that it would document the decision rationale in the veteran's health record. However, I understand that the VA will use a new referral process that could complicate referrals even more. I do not understand how creating a team to coordinate a decision is quicker or makes more sense than a veteran and provider making that decision.

I am also concerned that eight months into the program VA does not have a clear understanding of how many appointments have been completed in community care, and just as importantly, how much that costs, with the budget coming out next week. While I understand there is a lag time on medical bills coming in for completed appointments I do not understand how VA does not have an estimate of how much this is costing taxpayers, and with the President's budget coming in next week I do not see how that request will not be met with some skepticism.

I can tell you this. If the request shows a sharp increase for community care and level funding for in-house

care, VA needs to justify that and receipts to support that request.

Dr. Stone, I know you are absolutely, unequivocally a straight shooter, and I have no doubt that the policies you advocate are in the best interest of the veterans, and I mean that. But as chief VA witness today, it will fall upon you to convince me, and others on this Committee, that the VA is not simply sending veterans into the community because it is easier.

We also need your assurance that the IT program to support an expanded caregivers' program will be up and running by the end of the summer, which, as you know, is a full year after the VA was initially tasked with completing this project. This is an important project, and it is an important project to get moving. It is a project that Senator Murray and the previous chairman of this Committee wanted to get going, and I would tell you that the work on this is critically important for the veterans who have been waiting to be able to get assistance from the families and have not been able to afford to do that.

So, Mr. Chairman, again I want to thank you for calling this meeting. This is an important meeting. The MISSION Act, I do not need to tell anybody around this table or anybody at that table or any of the veterans sitting in the crowd that it is a very, very, very important piece of

legislation, that if implemented properly can be an incredible asset. If implemented improperly, can really take away veterans' care. Thank you.

Chairman Moran. Senator Tester, thank you for your opening comments. I do not know whether it is a reflection on the United States Senate or a reflection on the fragility of our relationship, but only in this setting can you get a compliment for starting a meeting on time, the only compliment I got from you.

[Laughter.]

Senator Tester. Listen, I think your wife dressed you very well today.

[Laughter.]

Chairman Moran. I feel so much better now. I got two compliments from you.

Dr. Stone, as I said earlier, welcome. This is Dr. Richard Stone. He is the Executive in Charge of the Veterans Health Administration. He is accompanied by the following: Dr. Kameron Matthews, Assistant Under Secretary for Health for Community Care, Veterans Health Administration; and Dr. Jennifer MacDonald, the VA MISSION Act Lead, also in Veterans Health Administration.

Dr. Stone, we recognize you for your remarks.

STATEMENT OF RICHARD A. STONE, M.D., EXECUTIVE IN CHARGE, VETERANS HEALTH ADMINISTRATION; ACCOMPANIED BY KAMERON MATTHEWS, M.D., ASSISTANT UNDER SECRETARY FOR HEALTH AND COMMUNITY CARE, VETERANS HEALTH ADMINISTRATION; AND JENNIFER MacDONALD, M.D., VA MISSION ACT LEAD, VETERANS HEALTH ADMINISTRATION

Dr. Stone. Good morning, Mr. Chairman, Ranking Member Tester, and members of the Committee. I appreciate the opportunity to discuss VA's continuing success in implementing the VA MISSION Act of 2018. This continues to be a time of transformative change at VA. The MISSION Act implementation is succeeding and has become part of our core business as we prepare to deploy additional benefits to support veterans and their families.

Alongside our DoD and HHS partners we intend to lead the industry in quality health information exchange, opioid safety, and ultimately care coordination powered by our new joint electronic health record.

Additionally, we will lead in providing services to veterans wherever they are, using the expanded reach of our new Community Care Program. We are building a strategy that will deliver health care excellence for veterans no matter where they choose to live or to seek care.

On June 6th of last year, we successfully launched the

new Veterans Community Care Program, a cornerstone of the MISSION Act. As the President promised, the MISSION Act has been good for veterans and good for the VA. Veterans now have enhanced care options and we are streamlining our processes and our technology to make their experience of care even better.

I would like to dispel any misconceptions about privatization. The VA health care system is stable, and we are growing in the amount of care we are delivering, and we continue to approach care delivery as an integrated organization ensuring veterans receive the right care at the right time, whether that be through our direct care system or through our community partners.

Since June 6th of last year, VA has authorized more than 3.85 million episodes of care in the community. But in the first quarter of fiscal year 2020, we provided direct care services to over 315,000 individuals each and every business day. That is 2,100 more individuals receiving care each day than the same period last year. That is more than 3,000 additional appointments every day in the direct care system.

You have given us, through this act, the tools and resources to make us the most accessible health care system in the industry. Our network of 880,000 community-based providers provide an unprecedented range of options for

veterans. VA remains committed to strengthening the VA health care system, expanding access, and pushing the boundaries of what is possible in serving our nation's veterans.

I would like to highlight the satisfaction rate veterans are experiencing using this new benefit. Veterans' expression of trust in VHA has risen to 88 percent in the last fiscal year. Similarly, our home telehealth program has had trust scores reaching 91 percent. This indicates successful efforts to provide trusted convenience wherever care is delivered.

Claims payment, timeliness to community providers remains a top priority as we modernize antiquated legacy payment systems. A new claim auto-adjudication system was implemented last month, and VA's third-party administrators under the community care contract, both TriWest and Optum, are paying the vast majority of claims in a timely manner. We are committed to being an excellent partner to the community providers who have expressed trust in us by signing contracts with our network.

Other aspects of VA's modernization and advancement under the MISSION Act include telehealth, the new scholarship program, the education debt reduction program. These are tools that you have provided us, in telehealth especially, that has allows us to bring provider expertise

across state lines. VA recently announced the delivery of telehealth services to more than 900,000 veterans and over 2.6 million episodes of care in the last fiscal year, an increase of 17 percent. The new scholarship program allows us to recruit by providing scholarship funding in exchange for a commitment to serve American veterans.

We knew when we began implementing the VA MISSION Act that we had the potential to make an enormous positive impact for American veterans. Today we have begun to demonstrate that potential. We will continue to work to improve veterans' access to timely high-quality care in VA facilities both in person and virtually, and we will augment this, when appropriate, with excellent choices through our robust network of community partners.

I am very proud of the future that we are building on behalf of America's veterans and their families, and sincerely appreciate this Committee's continued support.

Mr. Chairman, this concludes my statement. My colleagues and I are prepared to answer any questions that you may have.

[The prepared statement of Dr. Stone follows:]

Chairman Moran. Dr. Stone, thank you very much. Thanks for your opening statement and your presence here today.

The VA worked hard to find the best practices in the private sector and other federal health care delivery systems to land on where we are and the best standards for veterans' access to primary care, mental health, and specialty care. I am frustrated when I discovered that the contracts for Regions 1 to 4 do not incorporate the standards outlined in the MISSION Act.

My view is--I do not think this is controversial or disputed--is that those contracts must reflect the law, and perhaps the VA, although I would be skeptical that you could, could convince me that those are not the right standards, but I do not think that is a discretionary call for the VA. And so I am disappointed that the standards in the contact for Regions 1 and 4 do not reflect that.

The consequence, I think, is longer wait times, drive times for veterans that I represent. It is an example of where a requirement by law, that this Committee worked diligently to determine what it should be, is not being complied with by the VA.

I suppose, on one hand--let me say it this way. I am pleased to discover in the contracts with Region 5 the standards of the MISSION Act are incorporated in the

contract. So my hope is that this means that the VA is going to now incorporate those standards in the contracts for the previous Regions 1 through 4.

So Dr. Stone, can you and your colleagues tell me what I should know about my frustration?

Dr. Stone. Senator, I appreciate this discussion because I think there is a difference in interpretation of the law, and I think we need to resolve that. I think we are getting closer. You know, when I was with DoD we went through multiple versions of TriCare before. Now we are on seven or eight, and we are getting it right.

But I think that we have demonstrated in Region 5 that we need to place into the contracts access standards. Unfortunately, in highly rural areas, including in your own state, we are finding that even though our penetration of the market is higher than Medicare participation, in many counties, that we still would not meet either the 30- and 60-minute drive time or the 20- and 28-day standard. The American health care system is just not as robust as what we have committed ourselves to under the Secretary's leadership.

I will defer to Dr. Matthews for additional discussion. I think we can resolve this. I think it is very clear, and you have been very clear on what you would like us to get to. I just do not think that the American commercial health

care systems are prepared to comply in the manners that we would like to.

Chairman Moran. I do not think, Dr. Stone, that there is a requirement that, for example, the region that Kansas is in had a different TPA prior to today. The network is different. The providers are--there are providers that were utilized in the previous network not being utilized or contacted today. I do not think the requirement is, although that creates some--I do not think--let me finish the sentence. I do not think the requirement is that the same providers have to be utilized, or even the same number of providers.

But it does suggest to me that there is more outreach that could be done if the suggestion is that the private sector is not sufficient to meet the needs. The previous TPA was using additional providers than the current TPA, so that says something to me about expanding the network. And then the answer that we have received from the VA is that there is a study to be done, a utilization study, to determine what else needs to be done, and again, I worry that if you wait for a utilization statement, the veterans who are receiving care in the community will not be able to access that care and your utilization study will underestimate, undershow the demand for services and we will be shrinking the opportunities, not at least stabilizing

them or increasing them.

Dr. Matthews. Sir, we are definitely in agreement that this is an area that needs to be addressed with regard to providing the consistency between the regions. The background for Region 5, we placed that solicitation publicly after the MISSION Act was passed, so we had the access standards. If you also read the RFP, however, there is a very large section about waiver of those access standards that we actually adopted from the Medicare program, such that when the TPA recognizes that there is not the availability of providers, that they cannot meet those access standards, there is a level of criteria that they need to provide data upon to set a level of access that they can then produce in the network. And between the TPA and VA, we would then agree that, particular to those counties, to those area, that indeed that would be the standard there.

So the access standards, as Dr. Stone mentioned, would be our ultimate goal, but recognizing that contractually there is no way we could hold the network accountable to a level of adequacy that just does not exist in the industry.

Chairman Moran. I appreciate that answer. In part, I was pleased to learn about the new standards, the current standards being utilized in Region 5, but you are telling me they could be something less.

Dr. Matthews. Yes.

Chairman Moran. So maybe a little disappointment, perhaps in the right direction.

But I would conclude by saying that my expectation is that the TPAs in Regions 1 through 4 also have a provision that the standards can be increased or the demand upon them can be increased, and so it works both ways. And I understand that the standards were not in place when the first RFPs were proposed.

Dr. Matthews. Exactly.

Chairman Moran. We need to get us to the point, in my view, in which we are using the statutory requirements and they are uniform throughout the region. So thank you.

Dr. MacDonald. Senator, if I may add, I had the privilege, sir, of seeing you stand next to the Secretary and witnessing in person your commitment to access for veterans in western Kansas, and that is a goal we share collectively here with you and with the Committee. We want to make sure that no matter where a veteran chooses to live that they have access to not only our system but to the right care, and we believe that this is a cross-functional strategy.

That is what we are tackling now, that the network adequacy in community care is a piece of this. So is telehealth. So is deploying our providers with the mobile deployment teams that are set forth in the MISSION Act to

bring providers to rural areas where they need to be and where they need to meet people's needs in person. We think this is a cross-functional strategy that will need our partners' input as well and your feedback, but we aim to be, as Dr. Stone said in his opening statement, the most accessible and convenient health care system in history. And to do that we need both that network adequacy and the other pieces and tools in the MISSION Act that you have given us.

Chairman Moran. Thank you, Dr. MacDonald. Thank you, Dr. Matthews. Thank you. Yes, ma'am.

Dr. Matthews. Do you might if I just one more clarifying point, because I definitely heard you. This transition between our networks is a critical time. We need to assure that veteran care, first and foremost, is not threatened, that continuity of care is in place, and that we have adequacy to meet those needs.

I just wanted to also highlight, however, that under the Choice program, under PC3, the actual majority of care was not purchased through the network providers. It was purchased through what we called individual authorizations. A lot of times we were paying at higher rates. These were different sets of contractual agreements, if at all, between the VA and the providers directly.

Moving to the CCN realm is a very different space for a

lot of these providers, particularly our home health and dentistry providers, who were never networked with us previously. So we are really bringing on a different relationship than they had previously experienced and sometimes different reimbursement rates than they had previously experienced.

So walking the path between what was formerly, particularly under the Choice network, now PC3, to CCN is not exactly one-to-one.

Chairman Moran. Thank you. I look forward to resolving this, what I think we all agree is an important issue.

Senator, excuse me for going so long. It does not set a precedent. Senator Tester.

Senator Tester. Thank you, Mr. Chairman, and I appreciate your testimony, and I appreciate you talking about adequacy of care. I think we are talking about a different population than general population, and their challenges are greater because they often have multiple issues that they are dealing with. And so I think that is critically important.

As I look at my little local hospital, and I live in a very rural area, it is a great little hospital but I am not sure it could meet the needs of the veteran, just to be flat honest with you, at least not to the level that the VA does.

So thank you for that.

Dr. Stone, it is always a challenge to forecast how much funding it is going to cost for community care. There is just no doubt about it. It is a problem forecasting that, because it is an unknown that we have not got the metrics behind it to find out.

In 2017, as you well know, Congress stepped in three times to provide additional funding for the Department so it would not exhaust the Choice program funding. I am concerned that we may be headed down that path again.

Eight months into the new Community Care Program, VA has not provided, or cannot provide, one or the other, the number of referrals that became appointments. I get the number of referrals but we do not know the number of referrals that became appointments. And thus, I do not see how we can figure out how many dollars are associated with those appointments and whether usage is in line with the projections that you and other smart people have developed when this program was set up.

So Dr. Stone, do you have any concerns that the VA may be over budget with this program?

Dr. Stone. Senator, I think you asked the key question that keeps me up at night, and that is that this is a brand new program. In the six months before June 6th we sent 2.7 million episodes of care out. In the six months after, we

sent 3.8 million episodes of care out. But we have seen the appointing and the authorizations not turn into bills coming back in. Now we have way better criteria in our regulations on how long a vendor has to bill us. We have followed the Medicare standard that you have got to have the bill in in 180 days, so we can follow this.

Dr. Matthews briefs me on a weekly basis on the volume of referrals and authorizations, but we are still waiting for bills to come in. As we have seen this, it appears the authorizations are beginning to drop. We had predicted that there would be some kicking of the tires for community care and then it would drop off. That appears to be happening.

Now our burn rate through dollars in community care is running just over $1 billion a month. It may reach $1.1 billion. You gave us about $15 billion in the budget. I think we are safe, but part of this has to do with that timeliness of getting our bills paid, which is an absolute commitment that was in my opening statement. And we will keep you informed on a quarterly basis of our burn rate of dollars. But I am confident, at this point, that we are sufficiently funded, that we will not be up here asking for additional dollars.

Senator Tester. So in a previous program called Choice, one of the problems that I had, and one of the reasons I, quite frankly, beat the third-party provider up,

of which we have the two here sitting, that will be on the next panel, is because the providers were not being paid in a prompt time. One hundred 80 days, by my math, is six months, and if the providers are not getting the bills in in six months--and I will bring this up to the next panel--maybe the problem was not the third-party providers.

Dr. Stone. Well, let me say this. It can take a month for us to package a consult for routine care. That is something we are actively working on to fix and to get down to our three-day standard. That has actually been worked on in various sequesters for the last number of months. But at that point it is given to our third-party TPA, who then works to handle this, but it can take another month to get people in. If a provider does not get a--

Senator Tester. Because you are getting two mics, Dr. Stone? What the heck?

[Laughter.]

Dr. Stone. No. This is me in stereo.

Senator Tester. That is no problem.

Dr. Stone. This is me in stereo, sir.

Senator Tester. What is that?

Dr. Stone. This is me in stereo.

Senator Tester. Yeah, exactly. I get you in both ears.

Dr. Stone. So we are working to get this right. I am

as frustrated as you are, but I have to say to you that at this point our budget looks good and looks solid, but on a quarterly basis I think we need to be up here with leadership talking about our burn rate in dollars, and making sure we have got it right.

Now, by the same token, it appears that our funding within the direct care system is correct. But I want to think about the disincentive to a medical center director who, if they are short of funds, or think they are short of funds, can just say, "Well, I am just going to send everything out to the community because it is going to go to Dr. Matthews." And it is one of the weaknesses in the way we bucket funds in the current budgeting process. It is way beyond where you want me to go in a five-minute answer, but I will tell you we struggle with creating the right incentives to get care correct in the way we currently bucket funds.

Senator Tester. I will be very brief. The quarterly update is critically important and even more if necessary, in my opinion. And I will speak for myself on this, but I think working for flexibility in those dollars to make sure that the veteran is driving the bus, and they are going, that is really going to be critical. So that is all I have got. Thanks. I have got another round of questions but that is all I have got for now.

Chairman Moran. Thank you, Senator Tester. Dr. Stone, I think it is an awfully important point about the buckets. I can see the incentive process, circumstance being very problematic for the future of this, how we handle this.

Senator Rounds?

Senator Rounds. Thank you, Mr. Chairman. Dr. Stone, thank you to you and your colleagues for being here today.

In your written testimony, and then also in your visit with us earlier, you said that the MISSION Act implementation is succeeding and that VA is leading the health care industry forward. With all due respect, when it comes to paying provider claims, I would suggest that I have a very different opinion about what the definition of success should be.

In South Dakota, and Dr. Matthews was kind enough to come to my office last week and we had a chance to visit, South Dakota has got 880,000 people in the entire state. We have got about 8 percent of our population, or thereabouts, is veterans. I have got two providers alone already that have between $5 and $6 million in unpaid bills, and these are through the direct care program.

And I am just curious, these are the large providers. The small providers, the folks that really are part of that community care network that we want to be able to use, they are telling me that in some cases they have over $20,000 in

unpaid bills. And when you suggested that you were not getting the bills in a timely fashion and so forth, I am not sure where the hang-up is, but it seems to me that they are billing but we are not paying.

And right now we have got small providers out there that want to provide services to the veterans, and, in fact, they are, but at some point they are going to say, "I cannot afford to do it anymore." The larger guys, they will keep doing it, at least for a period of time. They may be frustrated and they may get angry. But there is something wrong with this thing right now, and we need to nip it as quickly as possible.

Dr. Matthews was in my office and indicated that she would do a short-term attempt to fix on the ones that we have got right now, but, look, this is not the way it is supposed to work. And I just want to disagree with you that this is a successful implementation at this stage of the game.

I would like to know where, if you--in listening to my discussion with you right now, if you can give me your thoughts about where we may be having this disconnect between where my providers are not getting paid and your thoughts that--it almost sounded like you were saying they were not sending the bills in.

Dr. Stone. Senator, I absolutely agree with you that

we are not where we should be, and in my opening testimony I said that we are changing antiquated systems. What I want to reassure you is this is not our third-party administrators. This is not Optum and TriWest. This is internal to VA and this is exactly the work that Dr. Matthews is doing to correct our processes. Our processes do overwhelming oversight to every bill, and it slows the process down.

Now when we came here a year and a half ago we were processing 100,000 claims a month. We are now processing over 1.1 million claims a month, approximately the number that we are getting in each month. But we have got to correct this backlog. So if we get a million claims a month and I say to you we have got a 60- to 90-day backlog, it does not take you very long to figure out how many claims that we are sitting on. That is an inappropriate place to be as a partner to any size business.

Senator Rounds. Dr. Stone, I think we are in agreement that it is inappropriate and that our goal should be to eliminate it. What I am looking for is the goal is admirable to eliminate the problem. What I am hoping to hear is what are the steps that are being taken to fix the problem?

Dr. Stone. There are three. Number one, auto-adjudication of the claims, using the eCAMS system and

setting up appropriate business rules to auto-adjudicate.

Senator Rounds. How long is it going to take to get that done?

Dr. Stone. My view is, and what Kam has reassured me, is that by this summer, within the next 90 days, we will be running really well with eCAMS.

Senator Rounds. So that would be a good date for us to target and see whether or not we are making progress.

Dr. Stone. Yes. Absolutely.

Senator Rounds. What next?

Dr. Stone. I think the second piece is to change our business rules on overwhelming audit, where we audit every claim, unlike Medicare that audits every 100th claim or every 1,000th claim. I think we can get that. That is being instituted as we speak.

Senator Rounds. What is it now and what is it going to, sir?

Dr. Stone. Dr. Matthews?

Dr. Matthews. We actually audit every claim prepayment at this point, just in order to avoid the fraud and waste of overpayment, the incorrect, underpayments. It is a significant amount of work that unfortunately is quite manual. We are trying to balance, of course, having accuracy of payment as opposed to--

Senator Rounds. Well, let me just ask, Mr. Chairman,

if you do not mind, then what you do, or what is your plan for when you are going to have that process changed, and what will it look like when you are done?

Dr. Matthews. Sure. That actually will be tied in with the auto-adjudication rules that are going into the new--

Senator Rounds. So within 90 days.

Dr. Matthews. Yes.

Dr. Stone. I think the third piece is enhanced contracts for outside vendors to pay bills. Even our third-party TPAs use outside companies to help pay bills. That, we just moved over 100 personnel against that contract contractually, to enhance this. I think all of this, you should see a very positive trend over the next 90 days with resolution as we go forward, and that resolution ought to be clear the next time we are talking about this.

Senator Rounds. Thank you. Thank you, Mr. Chairman. I will just say this. As long as those third-party payers get paid by the VA, it will work. But if you are not paying the third-party payers on time, it will not work very long.

Dr. Stone. And it is my understanding, and I am sure you will ask the TPAs sitting behind us, are we paying our bills on time, and it is my perception we are.

Senator Rounds. I have already asked the question, sir.

Dr. Stone. Thank you, sir.

Senator Rounds. Thank you.

Chairman Moran. Senator Rounds, thank you very much. Senator Manchin?

Senator Manchin. Thank you. Thank you, Senator Moran. Thank you all of you for being here.

I have got two questions. Dr. Stone, I think you know the first question, concerning the VA deaths. We have over 11 murders at the VA hospital in Clarksburg, West Virginia. It has been a year and a half, and maybe you can update me a little bit. I get calls every day still yet from families. And I know you were kind enough to come in and we talked about it, and I appreciate that, but if you have any new, updated messages or information that I can give to the families in West Virginia I would appreciate it.

Dr. Stone. Senator Manchin, you and I share our abhorrence of what occurred here, and I appreciate the time you gave me in your office to have a discussion of this. I cannot give you additional information.

Senator Manchin. Timelines?

Dr. Stone. I am subject to the same restrictions that you are. I meet with the IG every two weeks, and this is all in the hands of--

Senator Manchin. I have that the U.S. attorney, the one who was on the case, has left and there is another?

Dr. Stone. I am not aware of that.

Senator Manchin. You are not sure?

Dr. Stone. I am not aware of that. I can also tell you that I find out most through either the plaintiff's attorney or the media of what is going on here.

Senator Manchin. Well, and I hope--

Dr. Stone. And what I can assure you is that we believe that this is a safe site for veterans to receive care. You and I had that discussion.

Senator Manchin. Right.

Dr. Stone. We believe it is a safe site. We believe that we have discharged the employee that was involved in this, and we look forward to resolution. But the continuing pain in this community is intolerable.

Senator Manchin. It is just unbelievable, for the families who might have lost a loved one during that period of time that is in question, and if that person has died they still believe it could be attributed to the care they were getting. It is just very hard. And a year and a half. You have to admit to yourself no family should go through that.

So I am not here chastising. I am basically saying that the corrections that you tell me have been made, I have not had complaints since then from the patients and from our veterans, and I appreciate that. But I just do not have

answers, and my heart bleeds for the families I just do not have answers for.

Dr. Stone. Senator, I appreciate the leadership you have shown in this and the manner in which you have handled it, and I appreciate the time you have given me in discussing it honestly.

Senator Manchin. Please, and we will talk further privately.

Dr. Stone. Thank you, sir.

Senator Manchin. Okay. As far as on the MISSION Act, sir, I had my doubts about MISSION Act. I have got to be honest with all of you. I thought it was a back door to privatizing VA and I am very, very much concerned about that. I am on high alert, if you will. I have got 112 jobs unfilled in the VA in West Virginia, in my four VA hospitals, and some of those are in the most critical care. And to outsource that would not assure, in rural areas, that they are going to get the care outside. A veteran wants to get care in a veteran hospital. They feel secure there. They feel good. People understand their concerns, their needs, and where they come from. So my concern has been basically of not staffing in the specialties that we need and also the care that we can give.

I will give you an example. We did outside--there was outside immune work done, and we could do it inside if we

had basically the necessary equipment that it took for the investment. I think you and I talked about that, that they were able to do it for about one-third of the price and do it much quicker.

So I know the veterans hospitals in my area are capable of doing this work, and the veterans are much satisfied with it. But I also understand, and I appreciate the intent of MISSION was if you do not have it, shouldn't the veteran have the opportunity to have the best care? And I still feel very strongly. I am just concerned that we are abdicating our responsibility.

Dr. Stone. Let us talk just then a little bit about what we are sending out. Ninety percent of the increase in consultations that are going out to the community are specialty care. We are not seeing an increase--

Senator Manchin. I do not mean to interrupt you because I know our time is limited. But on that, do we have a good review process of the doctor who evaluates? Because I am understanding, if I am a veteran, I come in to the VA center, they evaluate me and decide where the best care would be. Is there anyone evaluating the evaluation doctor or that process is accurate?

Dr. MacDonald. Yes, Senator, and actually this is an area of intense focus for us right now. As we have briefed Committee staff, we are pursuing what we are terming our

referral coordination initiative. This is modernizing the way we process referrals, modernizing the experience the veteran has, and as clinicians sitting up here, I think we all understand walking out of a visit and waiting for the phone call about when that next step in care will have--will happen, the uncertainty of that.

We are changing that and bringing ourselves in line with industry best practice, and instead having a referral coordination team take care of that veteran immediately, do today's work today, as is a best practice, pass on the uncertainty and instead give the veteran certainty about when that care will happen and what that next step will be.

Senator Manchin. We would love to give you the input we are receiving, because we are not getting those same types of reports that you might, and we will give you the concerns that we have of how they have been evaluated and how they have been basically passed on.

Dr. MacDonald. Glad to hear that, Senator.

Senator Manchin. And it might be of help. I hope it does.

Dr. MacDonald. We are confident and we are actually very encouraged to hear that when most veterans are interacting with the new initiative, our referral coordination teams, that they are telling us that they want to be with VA, that they want to stay with us and have that

continuity.

Senator Manchin. They tell me this all the time. I just wanted to reiterate to you all and make sure we are doing everything we can to get the service within the VA system.

Dr. MacDonald. Absolutely.

Senator Manchin. And this should not be a privatization move at all, in no way, shape, or form.

Dr. MacDonald. Absolutely, and glad to discuss further, Senator.

Senator Manchin. Thank you. Thank you.

Chairman Moran. Senator Brown.

Senator Brown. Thank you, Mr. Chairman. Dr. Stone, thank you for the work you have done with our office, especially in Cincinnati. Thank you.

I want to build on Senator Manchin's questions with the same skepticism about sort of where this has all gone and the desire for some, many in the Administration and the Senate to privatize, as they want to privatize Social Security and the prison system and public education, all the things. I heard the President talk about failing government schools. That term just--I mean, I--most of us, certainly the three of you believe in public service as we all should.

The two topics I want to more specifically address for Dr. Stone, the quality of care veterans receive in the

community and ensuring VA medical centers have the resources they need to fulfill their missions. And similar to what Senator Manchin asked, but when we voted for the MISSION Act we never intended to have community care at the expense of VA care, especially when VA typically outperforms community health care facilities. And what Senator Manchin said about the comfort veterans feel when they are Wade Park, or they are at the Dayton VA, and the wonderful veterans hospitals around the country.

But I have heard VA facilities in my state, and I am going to guess throughout the country, have a budget deficit, and because of that deficit employees are going to be let go. My question is, Dr. Stone, are VHA medical facilities operating with a budget deficit?

Dr. Stone. Sir, they are not. There is no budget deficit. There is no hiring freeze.

Senator Brown. Have you changed your patient care model?

Dr. Stone. So here is what happened. When we stood up the new Community Care Program we loaded enough money, and we talked about this a little earlier, we loaded enough money into the Community Care Program that if I run short it will be a lot easier for me to come up and look at you and say, "I have got to pull money out of the purchased care and put it into the direct care system." So we actually

budgeted right on target, and we are performing right on target. In fact, last week we went into a budget burn sequester with all of our leaders of each of the regions. In 15 of the 18 VISNs we are right on target. In three we are burning a little hot, and I expect them to bring this--

Senator Brown. So let me--sorry to interrupt you--

Dr. Stone. And let me just finish this statement before you go ahead. We are about 1 percent off of where we need to be in those three regions.

Senator Brown. So if you have not changed the patient model and you do not have a budget deficit, how does a facility let 100 employees go over the course of three years and not see a degradation of services to veterans?

Dr. Stone. I am not aware that there are 100 employees that have been let go. Now there are some openings and there is some strategic hiring. Let me talk to you about that. One of our biggest problems is very high-cost specialists exceed the reimbursement--the pay caps that we have.

So a neurosurgeon or a gastroenterologist, a gastroenterologist can finish their residency and come out and command a $375,000 salary. We are capped at $400,000. So we have trouble recruiting in certain very high-cost specialties because of the pay caps, and it is something we are going to have to deal with.

I have got over 300 specialists that are at their pay caps today, so there is no sense of us hiring a neurosurgeon nurse to support a neurosurgeon if I cannot hire the neurosurgeon.

In California alone, one of the really high-cost markets for us, I have got over 400 nursing openings because we cannot compete. So we were just at UCLA and Los Angeles last week, working on the homeless issue. UCLA, across the highway from our campus, is picking off huge numbers of our nurses because we just cannot compete because of the pay caps.

Senator Brown. I guess I am not entirely convinced.

An unrelated topic. A year ago you told this Committee the Department was 90 days away from a recommendation on bladder cancer and hypertension and Parkinson's related to Agent Orange exposure. We have not forgotten. It has been over 300 days. We find the Department's response to reporting requirement by the end of the year appropriations package deficient. The science is there. Veterans deserve their benefits. You need to move on that.

Dr. Stone. Senator, I think what I said was that I had reached my recommendation to the Secretary, and the Secretary would make a decision. I think he has worked his way through that. I think he has made some statements on the additional data that we are requiring, and I will defer

to the Secretary to make the Department's definitive decision on that.

Senator Brown. So why is it taking so long? Why is the Secretary so slow?

Dr. Stone. I think specifically we are dealing with, especially in hypertension, a condition that affects 70 percent plus of over 65-year-old males in America. And so when you look at numbers on the Vietnam veteran population that exceed that by 5 to 6 percent, you really begin to wonder, what are we dealing with? Is it Agent Orange exposure or is it the fact that this may be a different demographic group? And I think we are struggling through that. So, therefore, the two studies that are still in motion and waiting for peer review and publication will either confirm this or not.

Senator Brown. So an administration that wants to give--and I do not put you in this category because you are not sort of in that position, but an administration that is very willing to give tax cuts for the richest people in the country cannot find their way to slightly err on the side of taking care of people who served their country in Tet, in other times in Vietnam, apparently.

Dr. Stone. Senator, I would say to you that what you should expect from me is me to base my decisions on good science.

Senator Brown. And I think you have, so thank you.

Dr. Stone. Thank you, sir.

Chairman Moran. Senator Brown, thank you. Senator Tillis.

Senator Tillis. Thank you, Mr. Chairman. Thank you all for being here. I was watching, Mr. Stone, and the Committee in my office before I came over, and in your opening statement you made a comment about very positive satisfaction levels. Would you repeat that again, where you are right now? I thought--did you say 80 percent?

Dr. Stone. We are at 88 percent, 88 percent for our routine, direct, face-to-face care of do I trust VA with my care and the care that I am getting. It is at 88 percent. We are at 91 percent for home care.

Senator Tillis. Yeah. So how does that compare against private sector benchmarks?

Dr. Stone. It is above private sector benchmarks.

Senator Tillis. Yeah. I think that is something that is always important to bring up here. Every once in a while I will go out in a public setting and I will hear someone say, "We do not want our health care system to be like the VA." I said, "Hell, I wish it was." I wish that we were achieving the same levels of satisfaction. It does not mean that we do not have work to do. It does not mean you are not going to run into kinks in the implementation of

MISSION. But you all have a very positive story to tell, and I am particularly proud of VISN 6 and all the work that they are doing down in the Southeast and specifically in North Carolina.

In fact, I am going to ask you some other questions about the implementation, but I think we just did a first-ever donation after a circulatory death surgery. It was a referral out of the VA for a veteran down at Duke University Hospital. Are you familiar with that case?

Dr. Stone. I am, sir.

Senator Tillis. Tell everybody else a little bit about it.

Dr. Stone. Kam, do you want to talk about that? You got it?

Dr. Matthews. Senator, with Ms. Seekins' leadership in that VISN--

Senator Tillis. It was amazing.

Dr. Matthews. --as you said, this was an unprecedented occurrence. And this really goes in line with the way that the health of our transplant program has been prioritized. We are seeing additional access for veterans in the community but we are also seeing veterans continue to choose VA and continue to choose, as you highlighted with Duke, the partnerships and the academic affiliates that VA has as a part of our transplant program.

Senator Tillis. Yeah. So I, for one, just want to let everybody know they are doing great work out there, and I like the way that you are going about making hiring decisions. You are right. It makes no sense to have support clinicians in place if the specialists cannot be hired. That is just good business sense. I am glad to see you are executing that way and I am proud of the Secretary and all of you all, incidentally, for the work that you have done on making the VA a preferred place to work in the Federal Government. It is great work, and that stems from leadership.

I do want to echo, Senator Moran raised a question about provider networks as we do the implementation from TriWest to Optum. And I am not going to point to an immediate concern now, at least within my state, but I think it is something that we have got to watch very closely as we roll it out and make sure that our veterans have access to the providers they prefer. It has got to be within the components of the contract.

But to the point Senator Moran made, it may mean that we need to look at it, and as you all said, provide some waivers, if necessary, to roll out and make sure we are primarily focused on the main thing. The main thing is satisfying the vet.

Also, I wondered whether or not you all do any surveys

on provider satisfaction. Do you all do that?

Dr. Stone. Internal to our system or those providers that are under contract?

Senator Tillis. Either one or both. It is just, you know, how happy are they working with the VA?

Dr. Stone. In our all-employee survey providers are singled out, and we are actually exceeding the benchmarks in the private sector for most categories.

Senator Tillis. I know you all have run into a few--I like the way you all have been proactive, particularly on reimbursements. When we have a problem, it looks like you are reaching out and really coaching the providers on how to submit the paperwork properly. That is good.

One question that I had is it seems as though it generally a once-and-done with the provider once they understand the process, but what more could we do to maybe even avoid that first interaction through education, portal access, whatever kind of tools we can use to expedite the transition?

Dr. Matthews. Senator, we are actually on our second generation portal for providers to be able to sign into and look at their claims and understand at what stage of the process they are in. We also have regular monthly webinars where our finance team is reaching out and working with different finance teams or even admin staff at different

health systems, and then there is that one-on-one interaction. We really are increasing our provider engagement in that way.

Ultimately, though, however, is also the larger transformation, not just automating how we process claims but to simplify the process, so there is not a confusion on where to send the claim. There is perhaps one clearing house. We are looking at that longer-term strategy as well.

Senator Tillis. Well, thank you all for the great work. I am going to submit a number of questions for the record that are more technical in nature, and, Mr. Chairman, I appreciate you encouraging me and Senator Tester to continue the check-in on the electronic health record and some of the transformation. I know we will be reaching out to set up a meeting in our office so that we can just talk through the program office and see how you are doing at the implementation level. Thank you.

Chairman Moran. Senator Tillis, thank you. Senator Murray.

Senator Murray. Thank you, Mr. Chairman. Dr. Stone, as you well know, it is really important to me to make sure that we are providing care for veterans who are facing fertility challenges as a result of their service. But I want you to know I am continuing to her about obstacles for veterans who are trying to access this care. I am hearing

that providers and veterans are unaware if the care is available, I hear about long delays in processing and approving the requests, and I have even heard about providers who are putting their own opinions ahead of the veteran and actually refusing to give them access to treatment.

It is really critically that after these veterans have sacrificed so much in their service they are fully supported, and fertility challenges are difficult enough without having to fight a bureaucracy to access care that they have earned and that they are entitled to. And as we all know, delays in this means sometimes they cannot access care and have kids.

So I do not want to hear about this anymore and I want to know what the VA is doing to address those barriers and make sure veterans get the care when they need it.

Dr. Matthews. Senator, this is such a critical point. We do have very structured guidelines, referral practices, so that the local staff, the local providers do have instruction on how to make these referrals, how to actually review fertility for service connection, because, of course, there are very strict rules on how we actually can provide fertility services.

But as you are hearing of these individual cases, our office can definitely make moves to make sure that these

individual veterans do receive the services that they deserve and are warranted to receive.

Over the last year or so there has only been about 400 or so cases. There are very small numbers nationwide. So we do have the capability to really dig in on each and every one of those and make sure not only that they are evaluated appropriately but that we also have a provider in network that can actually provide those services.

Senator Murray. Okay. Those are great words but I want to see them put into action, and I want you to know that we are hearing that that is not happening across the country.

Dr. Stone. And Senator, with each and every one of those, if we could have direct contact we would appreciate it.

Senator Murray. We do.

Dr. Stone. Because when a patient comes to you it often can take a little bit of time. We need that direct contact and appreciate the relationship that we have, that you will bring that to us.

Senator Murray. I will do that. All right.

Dr. Stone, another topic. Implementing the expansion of the Caregiver Program, as you well know, is significantly behind schedule. We have talked about this before. I have significant concerns over any proposal that would cut

eligibility or limit service to our veterans and their caregivers. And I do want to thank you for being transparent and up front with me about the VA's status when we met in December.

But it is time to get this program moving. Our veterans are waiting. These services can make a tremendous difference in their quality of life. So I want to ask today, when will we see the proposed caregivers' regulations and will they propose any curtailing of services or eligibility?

Dr. Stone. Dr. MacDonald has been working this actively, but let me say to you that it should be this month that you will see the regulations.

Senator Murray. This month, as in February?

Dr. Stone. As in February. Yes, ma'am.

Dr. MacDonald. Senator, the expansion of this program, as you know, is something we have welcomed in VA for a long time. We are thrilled to be able to provide this benefit equitably across all areas of care, and especially to be expanding first to those pre-1975 veterans, those Vietnam-era veterans who we know have a significant need set, and who we know face a burden of illness that is often higher, on average, than the cohort that we have previously served in the post-9/11 generation, individual by individual. Certainly any burden of illness can be high, but we know

that this cohort is significant, both in their own burden of illness and in the average age, as we anticipate, of the caregivers caring for them. Oftentimes this is a spouse who is delivering that care, day in and day out. Sometimes it is another family member.

But we expect the average age of these caregivers to be over 70. And by design, this program will meet the needs of each of these eras equitably. You will see us expand in a way that is consistent and builds upon the more than 15 programs that serve this population now. The stipend program that is specifically expanding, we are hiring more than 680 staff across the nation, and have hired them at the regional level, at the VISN level. In every region they are already in place, ahead of the expansion, which we anticipate this summer.

In addition, we have 50 percent, more than 50 percent now of the support staff on board, and we are in strong partnership with IT, stronger than ever before. And we anticipate that both the regulation, as it becomes final, as Dr. Stone said it will publish this month, but as it becomes final this summer that will come in line with the IT systems being delivered, and then this program will expand this summer.

And we anticipate, also, reaching back to those veterans and caregiver pairs who have already reached out to

us and expected this, as you said, on October 1st. We will be reaching back to all of those veterans who applied and guiding them through the process, if they still want to be part of the program when the expansion happens.

Senator Murray. Okay. We will be watching for that, and stay in touch. I am out of time but I did want to just say that I am hearing a lot of concern about the Department's referral process to community care and quality and coordination. I will be submitting a question on that and I hope to get an answer as quickly as possible.

Thank you, Mr. Chairman.

Chairman Moran. Thank you, Senator Murray. Senator Sullivan.

Senator Sullivan. Thank you, Mr. Chairman, and Dr. Stone, I am glad that you are going to be making it up to Alaska sometime this spring. I appreciate that. I think you will be impressed with the VA operations in the state. Dr. Ballard is doing a great time. And you will get a good understanding for our need for new or expanded spaces that can accommodate not just the uptick in personnel but as a result of recruiting initial doctors and staff, which has been very positive, the increased traffic of veterans seeking services, I think Secretary Wilkie saw this on his recent visit. My hope is that your visit will also encourage you and your VHA leadership team for operations

and management to reassess the way regional budget allocation models are setup to reflect booming growth.

So let me ask Dr. Matthews, I know you are aware that Region 5--and the Chairman, I appreciate, just touched on this--is several months behind Regions 1 through 4 in terms of CCN deployment, though TriWest is bridging in the interim, and we appreciate that. And in fee for the contract was solicited back in October of last year. What is the current timeline for awarding the contract?

Dr. Matthews. We are in the middle of the final stages of acquisition so we should be announcing in the coming month or two.

Senator Sullivan. Can you just--again, the Chairman just touched on it--can you go into a little bit more detail of why Alaska was pulled into its own network in the first place?

Dr. Matthews. Sure. So Region 4 was the original geography that we attempted to award, but VA did not find an offer of value. There was a lot built into that RFP that we then opted to amend. So we not only removed Alaska, when you look at the managed care industry there are not players that cover, from a network standpoint, Texas as well as Alaska. So that was a very large geography. Alaska tends to have actually just a couple of managed care players in that space, and they are solely in Alaska.

So by removing Alaska we wanted to make sure we had a more focused offer that was really focused on the needs of your constituents. We also did the same with the Pacific territories. They were also bucketed into Region 6. So it was really just an idea to get better offers.

Senator Sullivan. Well, look, we appreciate that, and I know you were taking input from a number of us on that issue. And when you are reexamining the Alaska market and drafting a new contract for the second RFP, how much input were you getting from the local VA leadership, which integrated into the final product?

Dr. Matthews. Dr. Ballard, other members of his team, as well as the VISN staff, were all included in that integrated project team. We also had multiple consultations with several of the tribes.

Senator Sullivan. Great.

Dr. Matthews. Tribal leaders joined us at at least two different meetings, and I was able to join as well, to discuss just what this RFP looked like, what the critical nature of the relationships within Alaska, just because, again, they do differ from other states. So we did a great deal of input in order to build this final RFP.

Senator Sullivan. Well, again, I appreciate that. You know, our Alaska Native veterans are a very, very high proportion, and we talked about that in the last hearing,

and then Alaska native health care has a lot of reach into some of our more very remote communities. You know, we have over 200 communities that are not even connected by roads. That is a challenge that no other state faces.

Dr. Matthews, how confident are you that the TPAs who have submitted bids for the Region 5 CCN contract will actually be able to meet the terms of it?

Dr. Matthews. Unfortunately, I cannot speak to that, just because it is a confidential acquisition process that I am not a part of.

Senator Sullivan. Okay. So anyone else? Dr. Stone, can you talk to that at all? I mean, I do not want to get into confidential info, but we want to make sure that all the work that you have done on the Region 5 issue is actually going to bear fruit. And if we do not think it will, what would be the alternative?

Dr. Stone. We are optimistic, and we are in that very sensitive stage of acquisition, and we need to be very careful with our comments.

Senator Sullivan. Okay.

Dr. Stone. But I can say that the Secretary and I were over with the Secretary of Defense last week, talking about the uniqueness of the Alaskan delivery market, the role the DoD plays with us, the role of the Alaska Native health care system, and it was specifically an expression of

our concern that as DoD evolves their health care system that we wanted to make sure there was no disruption with the very close relationship that our leader, Dr. Ballard, has had within the Alaskan delivery system.

But it is unique. You have helped me understand how unique it is, and now on my third attempt to get up to Alaska I am hopeful that we will actually do it this spring.

Senator Sullivan. Well, we look forward to welcoming you there, and I appreciate your comments on the uniqueness. But it does provide opportunities. We obviously have a big DoD presence there, which is growing quite significantly, more vets per capita than any state in the country, but also as you mentioned quite a solid and well-performing Alaska Native health system with reach, that the partnership with the VA we always see as a good opportunity to make the goal of what we all want, which is better health care for our vets.

So thanks very much. I look forward to seeing you in Alaska.

Dr. MacDonald. Senator, if I may very briefly follow on to what you just said about the uniqueness of Alaska, following onto our discussion earlier, in answer to the Chairman's question, this is where the tools in the MISSION Act need to come together with the other tools we have in VA. The Region 5 network itself will be a step forward, and

those partnerships, including the tribal entities, as you mentioned, will be critically important to access in that area.

Additionally, VISN 20, of which Alaska is part, is leading in the telehealth space, and leading in deploying our health care providers into areas where veterans need to see them in person. We very much believe that the tools you have given us in the MISSION Act--telehealth, the network, the recruitment and retention tools that we now have--need to come together and synthesize in order to meet access for folks who choose to live further away and would not have access necessarily to a brick-and-mortar facility. We need this to be cross-functional and meet them where they are, and your region is a primary example of how that strategy will come together.

Senator Sullivan. Great. Thank you very much. Thank you, Mr. Chairman.

Chairman Moran. Thank you, Senator Sullivan. Senator Blumenthal.

Senator Blumenthal. Thank you, Mr. Chairman. I noted, unless I am mistaken, Dr. Stone, there is no mention in your testimony of mental health care. Yesterday in the State of the Union, actually during the day, I hosted a family whose son and nephew, Tyler Reeb, was a Marine Corps sniper, had three tours in Iraq and Afghanistan. He came back suffering

from the invisible wounds of war and took his own life, all-too-common story.

The fact that it is so common is really an indictment of our health care system, and I wonder if you could tell me whether you have seen any changes in the quality of care, whether there are new kinds of treatments and diagnoses, whether the community health care that is offered through the MISSION Act is improving the situation, and whether we can do better to help our veterans before they come out of the service, removing some of the stigma and seeking health care, mental health care so that it is integrated with community service once they are back in the civilian world?

Dr. Matthews. Senator, this is, I think, for all of us, one of the most frustrating things we deal with. You have given us a doubling of our mental health provider budget. We spend almost $10 billion a year. We now have over 25,000 providers in mental health within VA. Access to VA mental health services is same-day access, across our entire delivery system, but yet we have not changed the trajectory and the number of suicides and self-harm that is created.

I talked extensively in previous testimonies about the fact that this is not simply a mental health problem. This is a problem of isolation and loneliness and hopelessness that really cries out to the rest of American society. It

is why the President, in his Executive order, called for the development of the PREVENTS Task Force and why the PREVENTS Task Force will present a plan that will integrate a community response, not dissimilar to what you saw in homelessness, that has driven down veteran homelessness by 50 percent.

VA cannot solve suicide alone, and if you gave us another $10 billion for mental health and we hired every single graduate of every single program it does not undo the intense loneliness that leads to this.

Senator Blumenthal. You do not think the problem is one of more psychiatrists and more trained professionals?

Dr. Stone. I do not. I do not, and I think we have demonstrated that. I think what this is--

Senator Blumenthal. And do you think--

Dr. Stone. --and I think we demonstrate that in the extraordinary difference in rates of suicide in areas like Montana, like Alaska, that have dramatically higher suicide rates than does New York City and Los Angeles. There is something about interpersonal contact that is protective, and it is why it is so important for us to maintain the mental health delivery system and the camaraderie that is developed in active duty that must continue when we leave. And it is why veterans choose us. You go into the lobbies of every one of our hospitals. Veterans stay there. There

is a sense of community that is really important.

I think it is also--and I know I am going on too long on this, but give me just one more second on this answer. There is a chance for us, in the transition program, to re-examine how we interrelate with the veteran. Right now it is up to the veteran, when they go through what we call our TAP program, whether they engage with us. We would like to consider an opt-out program where every veteran is enrolled in VA health care, unless they choose to opt out. I think it would help us a lot.

And the dramatic change, when I came off of active duty, from being in a cohesive community to what I experience now, I have talked about before, and I will not repeat. But I appreciate your tolerance of that prolonged answer.

Senator Blumenthal. Well, I thank you for that answer, and my time has expired so I cannot pursue some of the questions it raises. But I agree completely that the VA is sought after and welcomed by the veterans' community because of that sense of camaraderie, whatever the ailment that is being treated. That is one of the reasons that they come to the VA. And so I welcome your approach and I would like to follow up on it, and particularly, if you are willing to do so, meet with the Reeb family, because they have some ideas about how Tyler Reeb could have been saved.

Dr. Stone. I would, and I would welcome that meeting. Thank you. We will contact your office to schedule that.

Senator Blumenthal. Thank you. Thanks very much. Thank you, Mr. Chairman.

Chairman Moran. Thank you, Senator Blumenthal. Senator Hirono.

Senator Hirono. Thank you very much. I appreciate this discussion on suicide prevention because it has been a concern for many of us for, well, for all of us, I would say. So you mentioned, Dr. Stone, the prevention--PREVENTS Task Force? PREVENTS Task Force--what is that? They are supposed to be coming up with an integrated community plan for addressing--

Dr. Stone. This is part, Senator, of the President's Executive order, as we look towards the community approach.

Senator Hirono. I think that is a great idea, so I would like to have more information about who is leading this task force and when are they coming up with their recommendations.

Dr. Stone. This is, yeah, Dr. Barbara Van Dahlen, and this is an all-of-government approach to a different view, using a public health approach to suicide. And it really goes back to my previous comments, that this is not about really hiring more mental health professionals. This is really about an all-of-society approach, just like we did

with the homeless problem.

Senator Hirono. I understand and I applaud that much, much more of a whole-person approach to suicide prevention, knowing also that most of the suicides of veterans who take their own lives are not part of the VA. They have not engaged with the VA. So I really like your opt-out approach. So are you going to be implementing that?

Dr. Stone. So we just yesterday had additional discussions of that. This will require some help, and we will work our way through, from your level, how to actually implement that.

In addition, we have been talking about some pilot programs and expanding access through our Class 7 and Class 8 veterans that would not normally have accessibility at the same level to enhance that accessibility. And we are working on a pilot in VISN 8 on that, which is our Florida/South Georgia region.

Senator Hirono. So anything you can do to pretty much enroll all veterans in the VA rather than expecting them to show up, and doing that, I am all for, and if we need to change the legislation I hope you have something in mind.

The Director of the VA Pacific Islands Health Care System recently departed her position, and in the last six years, five to six years, you have had three different directors. And usually it takes quite a while for a new

person to be hired, and clearly we need somebody in that position who can connect with the community, including, of course, engaging with our neighbor island veteran populations, because, as you know, Hawaii is comprised of seven inhabited islands.

So I would like to know from you what is the status of the search for a new director for Hawaii? When can we expect a new person to come on board?

Dr. Stone. I would be happy to take that one for the record, and let me tell you only why. I have had a number of discussions with potential candidates who are interested in that. It is a very attractive site for a number of our leaders to go to. It is a bit of a dance when it comes to making sure that we are covering all areas properly and do not leave another area short.

But a number of our leaders within the system are interested in that job, and I will take that, if you do not mind, for the record, and get you the exact details of how close we are.

Senator Hirono. Yes, because the director in Hawaii also takes care of the veterans in Guam, right? I mean, this is a big job and we need somebody in there. And, of course, you mentioned before that recruitment and retention is an issue for the VA and you cannot compete with the private sector. But if there are things that we have to do

to enable you to better compete. Although one would think that working for the VA, you know, you can appeal to a sense of community, of being part of providing care for people who have sacrificed for us. I mean, there are these non-financial aspects one would think that would, I hope, be part of your recruitment effort.

Dr. Stone. I think it is. I think it is what has drawn all three of us to this job, these jobs, this sense of being part of something greater than ourselves.

Senator Hirono. So you do put that out as part of your--

Dr. Stone. Well, we do, but we also need to recognize that a young resident coming out of their training does not always have the same connection that we would like to the mission of selfless service. And I am not demeaning in any way, but--

Senator Hirono. Yes. More is the pity.

I just have--my time is running out so I wanted to ask you one more question, Dr. Stone. Mr. Atizado--he is on the next panel--mentioned that Disabled Veterans of America has heard from veterans that they are being offered access to community care network providers without being fully informed of their options to receive care in the VA.

So are you making sure that the veterans know that they can actually get care in the VA without having to go out

into the community?

Dr. MacDonald. Senator, thank you so much for raising this, and we are so grateful for our veteran service organization partners and feedback on this. We have heard this from actually several veteran service organizations.

As you heard me mention earlier about our referral coordination initiative, we want to make sure that veterans are empowered with their options. That has been at the center of our approach to the MISSION Act from the beginning. And I think we can safely say we have empowered people with their community care options. They are aware that that is an option.

What we are hearing from veterans, proudly so, is that they want to know more about what additional VA options they have. Can they use telehealth? Can they use an e-consult? What additional options do they have in the VA, even if they have to drive a little further?

That is beautiful news to our ears. We are proud that veterans want to stay with us, and that is why we are implementing that new initiative. That will get us down to three business days in scheduling people for care, empower them to schedule where they want to schedule, including if it is with us, and guide veterans through that process and really give them a list of options, which may be beyond their facility--that may be in their region and that may be

nationally, via telehealth. We are taking this very seriously and taking that feedback to heart from our veteran service organizations, partners, and what we are hearing directly from veterans themselves in our facilities.

Senator Hirono. Yeah. So what we are hearing is that they are not receiving the full range of options, and when you talk about empowerment, a lot of empowerment has to do with having the information necessary for them to make a decision.

I do have some other questions for the record, which I will submit. Thank you, Mr. Chairman.

Chairman Moran. Senator Blackburn.

Senator Blackburn. Thank you, Mr. Chairman, and I want to thank you all for being here. This is an issue that, in Tennessee, we talk a lot about, to our state director and our veteran facility directors. And we recently had a pretty poignant telephone call about some of this, because the wait times in Tennessee are exceeding the national average. Mountain Home facility, which is the best, the most highly rated facility in Tennessee, the wait times have increased since the implementation of community care.

So you get that push and pull from veterans and from the providers there within the VA system that they feel like they do not want you leaving the VA system and going to the community because they are making it difficult. The VA is

making it difficult for you to have your choice and have your options. And I know that you all have had some discussion before I got in here, from the Chairman, about this.

And one of the things that we talked about with RCTs, and this movement, is this going to be done from existing staff or is it going to be done from new hires, and what is the training process so that the veteran is the first consideration, not a byproduct but the first consideration?

Dr. MacDonald. Thank you so much for that question, Senator. You raise a critical issue about referral timeliness. It is first critically important to understanding that over the past several years VA has become extremely adept in delivering urgent care, and by urgent care I mean when a referral is urgent, when the care is needed now, and we need to get that veteran to care we deliver that in less than two days. Actually, it is continuing to go down and we are at 1.4 days. We deliver that internally and in the community right away, and we get those needs met.

Where we have work to do is in our routine referrals, as you mentioned, and we have that work to do across the system.

Senator Blackburn. And let me interrupt you right there please, and ask you, when we discuss this with our

center directors, what they will say is, "Well, it is because of the contract and because of the MISSION access, MISSION Act standards." So are you modifying those contracts, or where is the flexibility in that so that you are moving these forward and getting those wait times down?

Dr. MacDonald. Senator, this is two-fold, and it is about process. It is about our internal process. In the past, processes were fragmented between our internal traditional care system and community care. We are solving that by putting, as you said, the veteran is the priority. The veteran is at the center. They are empowered, as we were talking about earlier with their options.

When they have that range of options presented to them, immediately, again, doing today's work today, we are driving that wait time down to the three business days to process that scheduling.

Senator Blackburn. What is your timeline for getting it down to within a day?

Dr. MacDonald. Already, on Monday, all of our facilities conducted a stand-down, and--

Senator Blackburn. What is your timeline?

Dr. MacDonald. By July, ma'am.

Senator Blackburn. By July.

Dr. MacDonald. Yes.

Senator Blackburn. Okay. Let me move on in my minute

and a half left, and I know Senator Rounds talked to you about reimbursement. And we hear from people in small practices, not the big providers but the small practices, that they are not being reimbursed properly and there is a tremendous amount of delinquent payments that are there.

So how many community care reimbursement claims are backlogged, what is causing that backlog, and what is your timeline for clearing that backlog?

Dr. Matthews. Thank you, Senator, for that question. Currently, nationwide, our backlog, meaning aged claims beyond 30 or 45 days, depending on the population of claims, is 2.5 million claims. Our inventory as a whole is about 3.4 million, so there is always going to be some inventory because they have not aged yet. But that backlog is about 2.5 million. I do have a breakdown and can share it with each of you what your particular state backlog is, both by numbers as well as billed charged.

But yes, this has been an ongoing legacy issue for the claims submitted to the VA.

Senator Blackburn. What is your timeline for clearing the backlog?

Dr. Matthews. By the end of this fiscal year.

Senator Blackburn. The end of this fiscal year. And then your turnaround time per payment is expected to be what--15 days? 30 days?

Dr. Matthews. No. Our goal is definitely short of 30 days.

Senator Blackburn. Short of 30 days.

Dr. Matthews. Yes.

Senator Blackburn. Okay. Thank you. I yield back.

Chairman Moran. Thank you, Senator Blackburn. There is some interest in additional questions but we have a second panel that we think is also very important. Dr. Stone and Dr. MacDonald and Dr. Matthews, you have been very helpful to us. I appreciate the directness of your answers. We are going to turn to the second panel. I would guess that there would be, including from me, several questions for the record that we will submit to you. Thank you for your service.

Dr. Stone. Mr. Chairman, thank you very much. Ranking Member Tester, thank you. I appreciate the courtesy shown to us.

Chairman Moran. You are welcome.

We will call that second panel, which consists of Adrian Atizado, the Deputy National Legislative Director for the Disabled American Veterans; Lieutenant General Patricia D. Horoho, CEO of OptumServe; and David J. McIntyre, President and CEO of TriWest Health Alliance.

[Pause.]

Chairman Moran. Welcome to the three of you. I thank

you very much for agreeing to testify. We are grateful for your presence. I think it is particularly valuable that you were here to hear the testimony of Dr. Stone and his colleagues, and with that I would turn to Mr. Atizado for your opening statement.

STATEMENT OF ADRIAN ATIZADO, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. Atizado. Chairman Moran, Ranking Member Tester, distinguished members of the Committee, first of all I would like to congratulate you, Senator Moran, for your confirmation as the 12th Chair of this illustrious Committee. We look forward to working with you and your staff, sir, over your tenure here, to collaboratively work over the issues and make the lives of our ill and injured veterans better.

Chairman Moran. I look forward to that too, as well. Thank you.

Mr. Atizado. I want to thank you again for inviting DAV to testify at this hearing to examine the implementation of the new urgent care benefit and Veteran Community Care Program as envisioned by the VA MISSION Act that was passed a couple of years ago. Comprised of more than 1 million wartime service-disabled veterans, DAV is a congressionally chartered nonprofit veteran service organization. We are dedicated to a single purpose which is to empower veterans to lead high-quality lives with respect and dignity.

DAV is grateful for the support that this Committee and VA led to veterans, that led to veterans having access to urgent care furnished by the Department. Section 105 of the VA MISSION Act can be tracked to a 2016 resolution that was

adopted by our members, asking for urgent care to be included in VA's medical benefits package. And today the need for this benefit is abundantly clear, with over 170,000 urgent care visits made by veterans across the country.

Much of the success can be attributed to TriWest's efforts to build a network of over 6,400 urgent care providers as well as training them to understand the process and the procedures. And we are pleased to report that DAV members who have used this benefit express positive comments about their experiences, from the eligibility determination of the point of sight to actually the care that they receive, and not having been billed by it, which is extraordinary, I must say.

We are hopeful the transition of the urgent care in Region 1 from TriWest to Optum will be as robust a network and a process that is as seamless as veterans have experienced thus far.

Mr. Chairman, it should come as no surprise, though, the DAV vehemently opposes VA's decision to charge copayments to service-connected veterans for urgent care. This is a discretionary authority given to the Secretary, which he then exercised. In DAV's view, service-connected veterans have already paid any such costs for their service and sacrifice, yet VA breached this principle without attempting other means to achieve their desired ends.

I would like to turn now, at this point, to Section 101 of the VA MISSION Act. According to VA, the Veteran Community Care Program, which is embodied in Section 1 of the law, will be administered through a Community Care Network contract across five of six regions by the end of this year, and DAV recognizes the implementation of this program as a tremendous effort, and recognizes it is a massive undertaking, and its TPA partners, with TriWest and Optum, will really be needed. This partnership is critical for this program to work.

To help bridge this transition, as mentioned in this hearing earlier, VA has leveraged the PC3 through a contract and the Choice contract with TriWest helped bridge this transition. This is critically important. While DAV is unable to fully assess the progress to implement a high-performing integrated network, which is what the law envisions, we continue to hear, as was mentioned by Senator Hirono, issues--as well as the other Senators--from both veterans, VA providers themselves across the country, as well as community providers.

Mr. Chairman, we bring these issues to light so that VA and its partners can work together to systematically and holistically improve this critical program, and not treat it as one-off issues that they need to tackle as it comes up. VA is learning institution. Its partners should be, as

well, and this program should reflect that. They should not only measure but they should also be able to manage and identify them in the system.

To this end, we remain concerned about implementation of the required care coordination and competency standards of non-VA health care providers as required in Sections 101 and 133 of the VA MISSION Act. To carry out the care coordination piece, VA medical centers are assuming all responsibility in appointment and scheduling all eligible veterans, and I respect Senator Hirono's comments about the staffing requirements for these.

We also have not received fully sufficient information to assess the status of implementing the competency standards, in other words, the quality of care that veterans receive both inside and outside the VA health care system. Ignoring these standards shortchanges veterans and taxpayers of what otherwise should be high-quality and high-value care. It could also fragment veterans' care. This is something that should not be happening in a high-performance health care network.

Mr. Chairman, this is my time, and I appreciate the opportunity. I will take any questions from this Committee. Thank you.

[The prepared statement of Mr. Atizado follows:]

Chairman Moran. I thank you so very much. Lieutenant General, welcome. Thank you very much. I look forward to your testimony.

STATEMENT OF LIEUTENANT GENERAL PATRICIA D. HOROHO, (RET.) CHIEF EXECUTIVE OFFICER, OPTUMSERVE

Lieutenant General Horoho. Thank you. Good morning, Chairman Moran, Ranking Member Tester, and members of the Committee. I am Patty Horoho, CEO of OptumServe. On behalf of the more than 325,000 men and women of UnitedHealth Group, we are honored to be part of this mission. We have a long history of serving our nation's military and veterans, and we are deeply committed to standing up the community care network that honors the sacrifices made by our nation's heroes.

Half of Optum serves community care program staff, our veterans, and most of us have family members who are veterans. This experience is enhanced through extensive quantitative and qualitative research we perform to better understand veterans and their lives and their experience with navigating the health care system.

We met with 125 veterans in their homes over five states. We completed a national survey of 5,500 veterans, and then we mapped veterans' experience and steps in getting care, called the journey mapping. This research uncovered valuable insights and informed us on how the process would work better for veterans, for the VA, and community providers.

Taking in these insights that places the veteran at the

center of our planning, we are equally dedicated to excellence in execution. Center to our responsibilities and community care is delivering a network of high-quality health providers from which the VA medical staff and veterans can choose. We began by leveraging the 1.3 million providers in the National UnitedHealthcare and Optum provider networks, but our network strategy did not end there. We worked with the VA to identify quality providers. We have a history and a desire to care for our veterans.

Six months ago, we began health care delivery at two sites in Region 1. Today, in Region 1, our company has built a network that includes more than 178,000 unique health systems and providers across more than 309,000 care sites. And since we completed Region 1 implementation activities in December, the network has grown by more than 10 percent, which includes more than 18,000 unique providers, over 44,000 sites of care.

Taking a data-driven approach, we will continue to implement and evolve the network as we assess the needs of our veterans in Regions 1, 2, and 3.

We also care deeply about delivering a seamless experience for community care providers, including paying community care providers for care that they have delivered. This is a critical element to the success of our network. It demonstrates that Optum is a reliable partner and

increases provider confidence in continuing to participate in our network. As of today, we have processed more than 150,000 claims and paid claims in an average of 11.9 days.

Another critical element to the success of our network is resolving provider issues as soon as possible. As of today, we have received 35,000 calls to our customer service center from VA staff and providers, with an average speed to answer of 3.6 seconds, and our customer service staff have resolved more than 99 percent of the issues, first time, first call.

Throughout the entire provider experience we are providing them information that they need to take action. It begins with letters, calls, in-person meetings. After they have joined we provide training on how this new network operates. This occurs through webinars, in-person trainings, virtual town halls, and provider expos. We also provide regular updates, education materials, and on-demand videos to providers, either directly or through our online portal. We are restless in our desire to do more and learning, and leaning far forward to identify new ways and new methods to communicate.

In conclusion, what is important six months into health care delivery is that veterans are getting care from our network, providers are promptly getting paid, and we continue to adapt and build our networks across all three

regions, continuing our strong partnership with the VA and TriWest.

I am committed to continue to deepen our partnership with veterans, with Congress, veteran service organizations, and other important stakeholders. We understand your interest in ensuring the community care networks meet our veterans' needs and we share this interest. I am equally committed to continuing our open lines of communications and regular engagements with the VSO community, including Adrian's wonderful organization, and I am very proud to serve alongside you.

As a veteran, former Army sergeant general, and commanding general of the U.S. Army Medical Command, wife of a veteran, daughter of a veteran, and now the proud mother of an airborne infantry officer, getting this implementation right is important to us. We understand firsthand the compassion the VA medical staff bring to veterans, and the importance of coordinated care across the health system. This mission is personal and important to us. We understand why getting this right is so vital.

Mr. Chairman, congratulations on your new role leading this Committee. Thank you for what you and the entire Committee do every day to support our veterans, and thank you for this opportunity to testify.

[The prepared statement of Lieutenant General Horoho

follows:]

Chairman Moran. Thank you for your testimony, and thank you, General, for your and your family's service.

Mr. McIntyre?

STATEMENT OF DAVID J. McINTYRE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, TRIWEST HEALTH ALLIANCE

Mr. McIntyre. Good morning, Chairman Moran, Ranking Member Tester, and members of the Committee. I am Dave McIntyre. I am the President and CEO of TriWest Healthcare Alliance. Thanks for the invitation to appear today. I ask that my written testimony be submitted for the record.

Chairman Moran. Without objection.

Mr. McIntyre. Our company stands at the doorstep of implementing the new CCN contract in Region 4, which begins on April 7th in Montana and eastern Colorado, and will continue through the summer. Lots of work is underway between us, VA, at the local level and the national level, to make sure that we are ready to execute in our areas of responsibility, including making sure that the provider network is set for CCN.

But as most of you know, we at TriWest Healthcare Alliance have been on quite a journey the last six years, because you, we, and VA have traveled much of it together. The earliest days of this privileged work were extremely challenging, but our north star was two fully engaged members of the Arizona congressional delegation, one of whom, for which the MISSION Act is partially named, and the other one who now serves on this Committee. From moment one they were fully and completely engaged, seeking an

understanding of what was going on and pragmatic solutions to what needed to be done to make sure that Phoenicians who served their country were going to get what they were owed.

But the focus was not unique to Arizona. It was true across the nation. And it was true between branches of government and the veterans' community, including the great organization that Adrian is from. By working together, we brought things to a place of reasonable stability in the half of the country for which our company had the privilege of serving alongside VA, in terms of community care. We paid our claims, we assisted with appointing, we made sure that networks were available, and we performed other administrative functions, which you in VA worked at crafting the long-term blueprint for the future of VA, which is embodied in the MISSION Act.

Then we all found ourselves in a position where a company walked away from its commitments, leaving VA, veterans, and community providers in the other half of the country without the support that they were to have had. Senator Tester, I will always remember your graciousness in taking a meeting request from me when I was trying to decide whether we were going to accept the request of Dr. Stone to lean forward and plug the gap and build the bridge in the other part of the country. It was a rather intense conversation. It was very frank. Frankly, it is the

roadmap on which all of us at TriWest, in full partnership with VA, have adhered.

Not only that, I was impressed that when I said yes to Dr. Stone, you, in turn, said, "I am going to lean forward and I am going to be your partner, as is my staff in this process." You leaned out vulnerably and told the providers in your state that this would all work and that they could trust and have confidence that at the end of the day we were going to get it right.

In fact, three weeks ago I found myself in Montana, as I am often, but I was there at the side of my 85-year-old veteran father as he decided to take on the role of secret shopper in one of Montana's fine cardiac units, and they did one heck of a job, just as they have been doing for veterans ever since we went live in Montana on December 7, 2018, 90 days after we said we would assault that cliff.

As a proud American humbled to be of service to our nation's heroes in support of VA, along with all who are associated with TriWest, I tell you this story because it is a story that all of you are a part of, minus the flame that has at times been trained on my backside. But it is repeated for every member in this Committee, because we built that bridge together in the other half of the country.

It was done to strengthen, not weaken, VA. And great providers from across this country, some 685,000 on our

watch, with 1.3 million care sites of access, leaned forward. They have delivered care. They have delivered more than 20 million appointments in support of VA. In fact, because of them, we have returned less than 2 percent of care requests for no network provider.

We paid claims, 18 days on average, 10 days in the area of expansion, to an accuracy rate greater than 96 percent. With the exception of the last couple of months, because of a fee hold issue tied to the update in the payment rates, we have delivered on what we said we would do. We are almost out of the back end of that challenge.

As Adrian said, we stood up the urgent care benefit-- 175,000 encounters have now occurred.

So we are getting ready for the implementation of the CCN contract. We are proudly leaning forward. We are working at the side of the VA. We have sat market by market by market, over the last month and a half to two months, and reviewed what the demand profile is going to look like for the care needs in the community in each market, with our colleagues in VA. We have now factored that into the setting of our network, and the deployment of that network construction is underway with Montana and Denver being first, and we will be up and operational on April 7th.

Thanks for your leadership. Thanks for your partnership. Thanks for your fully engaged involvement in

support of veterans. It has been our privilege to serve at your side the last six years. Thank you.

[The prepared statement of Mr. McIntyre follows:]

Chairman Moran. Mr. McIntyre, thank you very much. Let me start where I started with the first panel, dealing with access standards under the MISSION Act. I realize that the Optum contract was entered into before the MISSION Act standards were in place. I was pleased that the contract that was negotiated for Region 5 included those MISSION Act standards. I learned from Dr. Stone and his colleagues that while that seemingly is good news I also learned that that may be something that can be waived.

My question is, what is your reaction to what I have been told this morning, and how insistent should I be in that the MISSION Act standards, access standards, be included in your contract, either by amendment or by Optum voluntarily meeting those standards, and how concerned should I be that there may be a waiver in Region 5 of those standards? And what does this ultimately mean to the ability for veterans across the country, particularly those who live in very rural areas, what does it mean for them?

Let me start with Mr. McIntyre, because you have been through both Choice and now MISSION.

Mr. McIntyre. Yes, sir. Thank you for the question. I will answer it with regard to Montana, where we are in the process of constructing the network that will exist for CCN Region 4, and Montana leads the deployment of that.

We have gone through a demand capacity process to seek

to understand the demand for care that will be going into the community. We use a rather extensive set of tools and they are very complex, that we use for urgent care. We are going to be mapping to what those standards are that are contained in the MISSION Act, and it is up to the VA, along with veterans, to decide when they will place care in the community.

Our objective is to make sure that we, to the degree that there are providers available to contract with, because they actually exist in the market, we will be seeking to make sure that there is sufficient supply of all the specialties that are required to be able to comply with the MISSION Act standards.

Chairman Moran. Thank you. Lieutenant General?

Lieutenant General Horoho. Thank you, Senator. The intent of the MISSION Act is really to make sure you have a robust network that is available for our veterans to be able to receive care, and it is near where they live. And so with that intent we have been aggressively building a network. When I talked about, in my opening statement, where we have gone live and met the standards of the contract, we actually continue to build our network to make sure that we are close. And I will give a good example.

So we are getting ready to go live in Georgia, which has about 159 counties that are rural, and 150 of those--

excuse me, 150 counties that are rural, out of 159. We have met the drive time. We will meet the drive time of 60 minutes versus what would have been in the contract of 100 minutes.

So we are trying very, very hard to continually adapt and build a network and build it upon referral data that we are starting to look at since November time frame.

Chairman Moran. General, we have had this conversation, my team and your team, as well as us. Is my concern that the failure to utilize the previous network of TriWest in Kansas, and awaiting a utilization study, those two things combined I am worried will find veterans once again experiencing the circumstance in which, one, they had care provided with a particular provider, now no longer available, and, two, the network is, at this point, not as large as it was, regardless of which providers are included in that network. And the end result of that is that--could be that there is a disappointment, again, in the ability to access care. I think, in many instances, veterans were discouraged in their utilization of Choice by experiences that caused them to throw up their arms and say "this is not working."

A significant goal of the VA and this Committee needs to be--and the TPAs--needs to be that there is no immediate dissatisfaction with this program so we do not disappoint

our veterans once again. What would you tell me that assures me that that is not going to be the case?

Lieutenant General Horoho. Senator, thank you for the question. I would say first is that we looked at rolling out community care very different than I think in the past of any other TPA. One is with our partner with TriWest, with the VA and ourselves, we made a commitment to put the veteran in the very center. We also stood up, where we have regular meetings, to be able to share and understand lessons learned, which we have applied. We make sure that in addition to leveraging our high-quality network we have gotten over 1,700 preferred providers that the VA wants us to put into that network.

In particular, we are also talking with TriWest and finding out who are those preferred providers, so that we can reach out to them. And then we have prioritized making sure that when we now look at the referral data we can see who those high-volume providers are and where the veterans are used to going, and we are then prioritizing and reaching out to them to make sure that we get them in our network.

Chairman Moran. Is your answer is that my concerns are unfounded?

Lieutenant General Horoho. I think, sir, when I look at your area in particular, we are going into your area with over a 97 percent accessibility, and we have not even gone

live yet. And so you have my commitment, and all of the leaders on the Committee have my commitment that we are going to do everything possible to build the most robust network to care for our veterans.

Chairman Moran. Thank you. Senator Tester.

Senator Tester. Thank you, Mr. Chairman. I want to thank all three of you for your testimony. I think it was very, very good. And I also want to thank Dr. Matthews and Dr. MacDonald for being here. I think it is really important that folks stick around. I know you can see it on TV, but it is good you are here so you can answer any questions, or they can ask you questions after the fact.

Adrian, I am going to start with you. You heard Senator Hirono ask about whether--ask Dr. Stone whether veterans are getting all the information that they need to make an informed choice on where to get care. What are the factors that are most important for the VA to cover with veterans when making health care choices, and do you believe that the VA has that information to assist veterans in order to make--in using it to make decisions?

Mr. Atizado. Thank you for that question, Senator Tester. So I think I will first start to answer that question by really making sure we understand which veteran we are talking about. If we are talking about a relatively healthy veteran, empowering them to make a choice would be a

relatively easy lift. But if we are talking about a population which is prevalent, in the population that VA treats, is older, aging, has a lot of complex conditions, they have life-long conditions, the kind of information they are looking for is more meaningful. It would have to be a little bit more information than one that is relatively healthy.

So, for example, if you are suffering from multiple sclerosis, which is a prevalent condition in the veteran patient population, you are looking at information that would be able to tell you, as a patient, would you want to have a life-long relationship with this doctor? Would I rather drive, can I drive, do I have the capability to drive to them if they were far, if they were of that value to me and my life, and how this would affect my ability to be an active member of society?

Now having said that, I understand the previous panel, Dr. MacDonald had talked about the RCT, which really is a kind of care coordination approach in making sure, as she has said, veterans are empowered. I find it curious, though, that what that effort entails is still unknown to me, to DAV. We do not know what that is other than what was mentioned in this hearing. It has been mentioned in passing, almost, but certainly not in full briefing. So I could not possibly comment on that, although I do understand

that this new responsibility that VA is taking on, under the community care contract, as far as scheduling and coordinating this care, is going to be quite different than what VA is doing today. And so I question what that effort is going to be.

So those are the two things I would say about that aspect, about what kind of information a veteran would want and need--it depends on what that veteran is facing in terms of health care needs--and whether VA is going to be able to achieve that kind of coordination.

Senator Tester. Okay. Thank you. As you know, the VA is undertaking market assessments across the country. As indicated, its teams are meeting with veterans and other stakeholders on the ground in different regions of the country. Can you describe your organization, DAV's involvement in these market assessments, and whether it is locally or whether it is here in D.C., and have you received any briefings on them?

Mr. Atizado. Sure. So with regards to the market assessments, Senator, I am not really sure which assessment you are referring to. There are actually two different assessments outlined in the MISSION Act.

Senator Tester. Pick the one you want. It is for the marketplace, though. Go ahead.

Mr. Atizado. So I want to be clear. Both assessments

have to be done separately. It appears that VA is trying to do one assessment, which is supposed to serve two different purposes. We believe that is the wrong way to go about it, but nonetheless, to describe our engagement with a market assessment it is probably best described as scarce.

Senator Tester. As what?

Mr. Atizado. Scarce. We have had scarce engagement on the market assessment. We know--

Senator Tester. That is not a good sign, especially for disabled veterans.

Mr. Atizado. No, sir, and especially that the law really intimates a consultative process that we would be more engaged than we are today. We are trying to bring this up to VA as a matter of course. We know they have a lot of things on their plate, but we would really like to have a little bit more engagement.

Senator Tester. Yeah, and I think it is absolutely necessary, and that is why it is good that the two VA folks are here. You can take that back.

I have--we will pass on them. I am out of time for now.

Chairman Moran. Senator Tester, thank you. Mr. Adrian, the RCT catches my attention too. I think there is a lot to be learned about what this involves, and I would be happy to work with you as we work with the VA to learn more

about it.

Mr. Atizado. Yes, sir.

Chairman Moran. Senator Loeffler.

Senator Loeffler. I want to thank you for your testimony today, for this panel. Lieutenant General Horoho, as Optum prepares for the rollout of the community care network in Georgia in two weeks, can you share what outreach has been done with veterans to talk about this transition and to prepare them?

Lieutenant General Horoho. Thank you, Senator. Our outreach primarily is with the providers and building the network, and then the VA actually is reaching out to the veterans. And so from our outreach with the providers is we reach out to them, we explain what the network--the responsibilities of the network.

We have online training so that they understand that training, they understand the culture of the veteran. We have online training in a portal that they can access that will show them about Psych Hub, because of the high suicide rates, so we try to address that right up front. And we have many other trainings that are there.

And then we do in person, meeting with the contractors and the providers that are coming in, and then we have the call center in which they can call into as well. We are looking forward to actually serving your veterans in your

area.

Senator Loeffler. Right. Thank you.

Lieutenant General Horoho. Thank you.

Chairman Moran. Anything further, Senator Loeffler?

Senator Loeffler. Nothing further. Thank you.

Chairman Moran. Senator Tillis.

Senator Tillis. Thank you, Mr. Chairman. Thank you all for being here. Mr. Atizado, I want to ask you a question. I know you said in your opening statement you were vehemently opposed to the copay for urgent care.

And I guess the question, in North Carolina, since the MISSION Act was implemented, I think we are ahead of every other state, adjusted for population. We are at nearly 10,000 urgent care visits since it was implemented back in June. And I understand it is a $30 copay after the first three--is that correct?--the first three urgent care visits in a given calendar year?

Mr. Atizado. So yes, sir. The copayment schedule includes that. There are some veterans that have to pay on their first visit.

Senator Tillis. Disability and other factors come into play. Is that correct?

Mr. Atizado. Yes, sir.

Senator Tillis. Service related or not?

Mr. Atizado. Yes, sir.

Senator Tillis. So is the concern with the copay, is it more where that could lead to other policy decisions, or just on its face you think it is inappropriate?

Mr. Atizado. Sir, so on its face we think it is inappropriate, and there are a number of reasons, a couple of which I will bring to your attention now. When a veteran is trying to engage a complex health care system, the more standard it is for that patient, the better. So they start having to engage a different part of their health care benefit and having to determine whether or not they have to pay copayments, that adds to a little bit of that confusion, for one. And really the more important one is the principal nature of that.

Senator Tillis. Yeah. Well, that is what I was wondering. I am just trying to figure out, on the one hand you want to provide that benefit. On the other hand you also want to make sure the lowest cost, high quality provider that can provide whatever care is in plan. I am assuming that was some of the rationale behind it, but that is something I will look into a little bit later.

Tell me a little bit about what you are doing. You guys do great work and you have helped a lot of veterans through several transitions--PC3, VA Choice, and now MISSION. What are you all doing engaging--in your VSO, what are you doing and what can we learn, what other VSOs could

do to help with these transitions?

Mr. Atizado. So I think what we are getting ready to do is do a survey of our members. That is going to be a point in time, and I think we are going to do this in a recurring event.

But I think the first thing that should be done is for us to do some inreach with our members to find out, in a general sense, how they are experiencing this program. I can tell you that there are some parts, as mentioned in my testimony, where they are feeling some disruptions. We feel some of them are quite unnecessary.

And once we get the sense of how it is operating, how they are experiencing, then we will take this to VA and see whether or not they are, in fact, identifying and measuring these issues, and then fixing them, in a systematic way. Because doing one-offs, this is an evolution that is going to be going for years. I think that would be a little bit better approach.

If I can just go back real quick to the urgent care benefit, we were very instrumental. We worked with Senator Cramer and this Committee on that provision in the bill. Our proposal at the time was to mimic what DoD's Defense Health Agency was doing with regards to the urgent care benefit, because it would reduce their overall cost in other areas.

How the Defense Health Agency did this was they used a nurse advice line to help manage that need. They would direct the patient to the appropriate venue, preferably the least costly and one that is most responsive to the need, but that is not the approach the VA took on this.

Senator Tillis. That is something we should talk more about. In my remaining minute, it is less of a question. TriWest has a larger network in Region 1, but larger does not necessarily mean that Optum needs to get to that point. What we will be tracking, as you go through the implementation, are any unserved or underserved areas within North Carolina. It sounds like the analytical approach you are using to figure out where to go to get additional providers should stay ahead of that, but, you know, expect us to continue to reach out and see any areas that may be one-offs. But I hope that in response to the Chairman's question, that you are going to stay ahead of it.

I will also tell you that I make an offering several times a year to any provider whose bills are not getting paid on time in North Carolina. They are a constituent and we treat it like casework. So I am glad to hear that you are doing a good job on reimbursements. That is critically important.

And I am over, but take rate, when you do your analytics you identify another provider that you need to get

into the system. What is your success generally in getting that on board?

Lieutenant General Horoho. Actually, we are having a very high success rate. There are some academic affiliates that it takes a longer process to get them in, and that is probably where we see the longer timeline. When we see individual ones, they tend to come into our network a little bit easier.

Senator Tillis. Well, in any instance where you are looking at a provider in North Carolina and we can help, let me know.

Thank you, Mr. Chair.

Lieutenant General Horoho. Thank you, Senator.

Chairman Moran. Thank you, Senator Tillis. Senator Sinema.

Senator Sinema. Thank you, Mr. Chairman, and thank you to our witnesses for being here today, especially to my friend David McIntyre, CEO of TriWest, and of course a proud Arizonan.

We are, in large part, here today because in 2014, the Phoenix VA Medical Center was at the center of a national scandal in which veterans experienced dangerously long wait times for medical care. That crisis led to the Choice program and now the community care network established under the MISSION Act.

The VA has made steady progress improving transparency, wait times, and access to care, but much more work needs to be done. I am extremely concerned about the time it takes for an appointment to be scheduled after a VA clinician has referred a veteran for community care and the processes that contribute to that delay. According to VA data provided to the Committee in December, the national average is 27 days between a VA clinician referring a veteran for community care to the scheduling of a veteran's appointment. The average in Arizona is about 25 days across our three VA health systems, and that is unacceptable.

So those data do not account for the wait time between making the appointment to actually seeing the community care provider. These delays have serious consequences for the quality of care and experience that veterans and their caregivers have when engaging with the VA.

For example, Sharon Grassi is an Arizonan, an Elizabeth Dole Foundation fellow, and a caregiver to her son, Derek, an Army veteran who served from 2006 to 2015. He returned home with spine injuries, post-traumatic stress disorder, traumatic brain injuries, and more. Sharon worked closely with my staff outlining the challenges she has had moving in and out of the Choice program, and now the community care network.

In one of her more recent challenges, Derek's VA

provider referred him to community care because the VA did not have a specialist he required. But when the order was reviewed within the VA, it was modified without consulting the original clinician and Derek was not assigned to the specialist. This created confusion, delays, and deep frustration for Sharon and her family.

In Sharon's words to me, "The order had been modified without talking to Derek's doctor, without researching his case, understanding the diagnosis, or determining the capability of the facility. In the VA system a doctor's order is transferred to a purchased care team, forwarded to a department head, and given to a voucher examiner before being approved for care, and during this process clinically necessary care is delayed, modified, dropped, or lost. When community care is authorized, communication between providers is stunted, record management is horrible, and record-sharing a dysfunctional mess."

Sharon praised the Phoenix VA and so many of the providers who have supported Derek, but voiced frustration with the process. She ended her letter to me with relief, because their petition to the Army to change Derek's discharge to medical was granted. He will now use Tricare services moving forward and not the VA.

The VA has a real problem when a caregiver or a veteran are excited to be out of the system and receiving care

somewhere else.

So I have got several questions now for our panel. My first is for Mr. Atizado. What is your understanding of the VA's process when a VA clinician refers a veteran into the community care network, and what are you hearing from your members about that process?

Mr. Atizado. So, Senator Sinema, thank you for that question. It is disappointing to hear that situation you just described. Unfortunately in our casework it is not an isolated incident. It is absolutely--it is infuriating to hear that a veteran who has agreed on a treatment plan with their provider is changed by some faceless individual. That should not happen. I am sure if you were to ask VA that they would say that that should not happen as well, but the problem is that it does.

I will be honest with you. I do not know what the process is now, because of how community care has changed over the last several years, not to mention there are still a couple of authorities out there which has different processes in place, and now we are talking about another change in how VA does their business, when referring veterans out in the community.

But that should not be the case. That expectation should be preserved. Senator Tester asked about what information veterans would need, and I think that really

comes down to that first question, is that VA provider needs to sit with that veteran and know what they want and what they need. You want to talk about veteran-centric? That is it. When they agree on that treatment plan the veteran is not only encouraged to comply with that plan but somehow VA, in this particular instance and in others, does not. I do not understand it.

Anyway, I apologize. Thank you.

Senator Sinema. No apology is needed. I think we all share this frustration.

Mr. Chairman, my time has expired. I do have further questions for members of the panel. I will just submit those.

Chairman Moran. Thank you very much.

Senator Sinema. Thank you.

Chairman Moran. We are going to do a second, hopefully relatively quick round. Let me--in regard to Senator Sinema's question, and particularly again while the doctors from the VA are here, I think an issue on the wait time is that the VA considers the wait time not to start--in other words, do they comply with the number of days--it does not start until they schedule the appointment. And the issue in my view should be the wait time begins when they make the decision for the referral. So we need to make certain that there is not a significant gap between the decision to refer

and then the scheduling of the appointment, which then perhaps, under somebody's theory, extends the amount of time in which you are either in compliance or not.

I have a question, which causes me to pull up my iPhone. I looked something up because I have tried for a decade. The conversation about mental health--maybe this was Senator Blumenthal--we have, in Kansas, and perhaps it is true in other states, we have something called community mental health centers, and they are created by statute. They are the gatekeeper for our state hospitals, but most importantly they provide mental health services in the community.

According to their website, the way they are defined is "a community mental health center are charged by statute with providing community-based, public mental health services safety net. In addition to providing the full range of outpatient clinical services, Kansas' 26 community mental health centers provide comprehensive mental health rehabilitation services such as psychosocial rehabilitation, community psychiatric support and treatment, peer support, case management, and attendant care."

I have tried for a decade, in fact, before Choice and then under Choice, and now under MISSION, to make certain that a community mental health center qualifies for a referral from the VA for mental health services. I ran out

of time to ask the VA this question, but are those community mental health centers being contacted? Are they being offered the opportunity to be a provider in the network? And, I guess finally, the reason this is so important is timing for all health care is critical, but in today's efforts to reduce suicide requires providing mental health services quickly, and I assume where a person lives.

I heard what Dr. Stone said about wrapping people in other people, and it is not always about the mental health professional. It is about being surrounded by people who are going to care for you. Our community mental health centers do that every day for Kansans and they do it in the most rural settings of our state. Can I be assured that they are being included in this network and can provide services under MISSION for veterans?

Mr. McIntyre. So Mr. Chairman, if you look at the network that we constructed over the last number of years, many of them are in the network that we have, and as we set for CCN the next network in the states that will be responsible for we will be porting them over. Many of them, though, had direct contracts at one point with VA, because some of this care used to move directly. Now it is moving through a consolidated network.

In fact, in the state of Montana, Senator Tester's staff, myself, personally, and the VA team on the ground are

going to meet together in Montana with the four facilities that fall under that definition, because their contract directly is aging out and we will be bringing them together into the footprint of the network for Montana as we map demand against supply.

The last thing I would say is you are right. The other Senators that have articulated this were right. It is about human connection. And the bottom line, at the end of the day, is what people say that did not commit the act of suicide but thought about it, I did not do it because I saw someone or I heard someone or I felt like I needed to be there for someone that was on the other side.

We do a lot of mental health appointing in this space for VA. We also run a stress program that we built for the Marine Corps years ago. We have never lost a Marine through that program. We are in the process, as our contribution to suicide prevention, of marrying those two pieces together so that appointing will not just be appointing, it will also be a place that people can go to have lifelines. And we are going to build a 24/7 apparatus against that, just like what we operate for the Marine Corps.

Chairman Moran. Yes, ma'am.

Lieutenant General Horoho. Senator, if I could just share, actually, a story. You know, we have our call center and our call center is actually for providers and the VA

staff, for any questions that they have got. Well, we had a veteran that called the call center, and one of our techs that answered the phone was talking and realized that he seemed very, very stressed, and started engaging him in conversation. During that conversation, he actually shared that he had a plan to kill himself and had the intent to do that. She was able to be decisively engaged with him, got him care, and actually saved a life.

So when we talk about trying to prevent suicides, it truly is a comprehensive touch point. It is that personal connection. It is making sure that everybody that is serving our veterans, or part of community care, understands the personal engagement and understands warning signs of someone who either has mental, physical, spiritual, emotional, or financial stressors, because all of that plays into someone when they start feeling hopeless.

Chairman Moran. Thank you. In regard to--I appreciate that story and it is--I mean, humans, as we are, we need somebody who loves and cares for us, and it is important. I would ask you to follow up with me about the issue of community mental health centers in Kansas and being in the network.

Finally, and my time has expired as well, but I want to say that our experience--there are 125 hospitals in Kansas. I visited all of them. I do it on an ongoing, continual

basis. And I am always touting the Choice program as an option for particularly those rural hospitals to help meet the needs of their veterans. It does not appear to me that many of them know about the MISSION Act. They have had experiences with Choice. Some of them decided not to participate--continue to participate in Choice because of lack of payment, inability.

Mr. McIntyre was very helpful in making sure our hospitals were reimbursed at a Medicare rate sufficient to cover the cost of providing the service, as they are under Medicare, because of the nature and size of their hospital.

But I would encourage greater efforts, by both the VA and the TPAs, to have outreach and convince the provider that it is something that they can afford to do, because they want to do it.

And then, finally, we have discovered, and we need to take this up because I think with our VISN, because VA's outreach is occurring at the state and local level, the local level as compared to the central office, we have lots of veterans who have little information or understanding of MISSION, and it is always the surprising thing. It is a significant role that VSOs play in trying to get information and opportunities understanding to veterans.

This change is something that I still think that many veterans do not know what their options are, within the VA

or the VA's referral to the community.

Senator Tester.

Senator Tester. Thank you, Mr. Chairman, and then what further complicates that situation are the veterans out there that do not use the VA and are not apprised of those services, and, quite frankly, it turns out bad.

I would say this, generally. The person, the employee that did what that employee did needs to be commended, because a lot of folks would have said, "Gee, this is not in my job description, so what the heck." And so I just--when you get people like that, they need to know that they have done a good job, and in a job that oftentimes many of us would not have done. And so I just think that is important.

Dave, I want to talk about providers getting paid. We both know it is a key component. If you are going to have folks in the network they need to get paid in a timely manner. We have both heard concerns in Montana about late payments. Could you explain to me the process for paying ER claims and non-ER claims? Are they the same? And if they are not the same, what is the difference?

Mr. McIntyre. Yeah, you bet. Great question, and there is no question about the fact that when you order came from somebody you are supposed to pay for it, right, and on time, and accurately.

We have some challenges between us and VA at the moment

around emergency room care and the claims related to that. The claims for emergency room care were directed to come to us as a corporation for the purpose of paying the network providers that we have in network, which is a large network across the country, for emergency room care. You cannot pay those claims without the actual authorization itself from VA.

And so we and VA are in the process of discussing right now what do we do about this? How do we make sure that those things are going to be properly processed? Those discussions are underway? They are very accelerated. There was a very late-night conversation two nights ago between myself and the COO for that part of the system in VA for an hour. We were looking at options that were viable. What I told VA is I am not sending those back. I am not denying them. We will go red on performance before we will send things back and put the providers in a do loop on the other side.

So it is important that this ER stuff is getting handled differently than it was historically. I think people were very well intentioned about what they were thinking might make sense, but it is a process piece that needs to catch up so that we can make sure that we get this right.

Senator Tester. Okay. Thank you. And are you getting

everything that you need from the VA, and can you tell me what the problem is and whether the providers--what kind of timeline for improvement?

Mr. McIntyre. So in terms of ER?

Senator Tester. Yeah.

Mr. McIntyre. I was very gratified to get a call two nights ago from the senior leadership to say, "Are you available?" And we were on the phone from 9:30 to 10:30 at night. I know those people personally because we have done a lot of work in the claims processing space over the last couple of years. Dr. Matthews has been directly engaged, as has Dr. Stone, and I am confident, based on our collective track record, that we will figure out the right answer. We will get this line unkinked, and it will not get kinked again.

Senator Tester. Good, and thank you, and I once again want to thank you, as I did the first panel, about being here. I appreciate you guys' input. As you know, and as we all know, quite frankly, good communication is the key. And if we have good communication and we know what the problems are I think this Committee will work to try to solve them.

Adrian, I appreciate your testimony and I appreciate the fact that we can do better, and I am talking about we, the VA, can do better, with talking to the veteran service organizations to make sure they are meeting the needs. I

have said it many times. We take our direction from the veterans, and, quite frankly, we need to pay attention to what they are saying if we are going to meet their needs. And I thank you for being on the panel.

Chairman Moran. Senator Tester, thank you. We are just about to wrap up. So that Senator Tester does not have the last word I have something more to say. But his comment is the precipitating factor for saying this about veterans who are not in the system.

So our first effort at trying to provide for Kansans who live long distances from a VA hospital, again, a congressional district the size of Illinois, that had no VA hospital, was outpatient clinics. And we were successful in getting these outpatient clinics in lots of places, in a significant number of places, across Kansas.

In my hometown of Hays, the VA opened an outpatient clinic. The VA estimated that 1,200 veterans would access care at that clinic. Within six months, the number was 2,400. And what the difference was is the VA estimated how many veterans in northwest Kansas are driving to Wichita to access care, who will now stop in Hays, which is 2 ½ hours closer than Wichita, to where many of them live, and access care through the outpatient clinic.

What was not taken into account were the veterans who were accessing care nowhere. And so the VA--we, as a

committee, you, as third-party administrators--have a significant--I would add the VSOs have a significant opportunity here to make sure that fewer and fewer people are in that category of getting care nowhere. And so I offer to you and to the VA and to all the VSOs our help in trying to make sure we get the opportunity available to people who otherwise receive no service from the VA, but are entitled, are eligible.

So it is a constant effort. And again, I have been surprised my entire time in dealing, in having relationships with veterans, how many of them do not know what they are eligible and entitled to do.

Mr. McIntyre. Sir, as you work the question of education, and everybody else works that at your side, what I would say is the way we collectively approached urgent care and the construction of that is exactly the way you need to construct the network backbone, whether it is direct system or whether it is purchased on the outside.

And what we did is we took a set of mapping tools, and we looked at demand ratios. We looked at the actual address of a veteran, and we looked at the footprint of where the locations were for providers. And then by ratio we developed what we felt like the network footprint needed to look like for urgent care.

Today, more than 90 percent of veterans have access to

urgent care within 30 minutes of their house. That was the requirement. And so that is the same approach we have taken to refine the current network, and the approach that we are going to be taking to the core network.

And I believe, listening to General Horoho talk about the approach that they are taking to try and assess and figure out what the need ultimately is going to look like in the territory that they are walking into, that she will arrive at a place that is similar to where we are. We have a little bit of an advance run because we have been at this the hard way for the last six years, and we, in VA, have assessed what that demand profile looks like, where the locations are, what kinds of gaps there are, and we are going to have that at the core of how we are doing network construction for Region 4.

Chairman Moran. General Horoho, just like I cannot let Senator Tester have the last word, I give you the opportunity to make sure that Mr. McIntyre does not either.

Lieutenant General Horoho. Thank you, Mr. Chairman. Probably the happiest I have been all day.

[Laughter.]

Lieutenant General Horoho. What you raise is such a critical issue, and I just want to raise it up a little bit to a higher level.

So about a year and a half ago we looked at doing an

executive development program, and one of the ideas that we looked at was individuals that are dual eligible for insurance, right, that are getting commercial insurance but are also eligible for VA and disabilities, and they do not even know they are.

And so we actually put together a program and looked at it, and one of the things that we found is we fail within the commercial sector to ask someone, "Are you a veteran? Have you served?" Because when you do that it changes the conversation in how you provide care.

The second thing, and probably one of the most powerful stories that we shared across our company, is one individual, an Air Force veteran, in his 70s, had never ever applied for disability, did not even know what his opportunities were. We talked with him. They connected him with the VA. He went through the process. He ended up being able to get medication that he could not afford when he did not have his disability, and actually him and his wife made a decision who was going to get medication. He got the medication that went from $400-something a month down to about $4 a month, and he realized that he had the eligibility for burial and insurance.

It completely changed their lives at the age of 70, and I think that is an example, when we talk of this shadow population that has given so much to our country, and they

have not tapped into all that they are eligible for.

Chairman Moran. General Horoho, thank you very much for that example. It is something that I do not know that I had thought about, is the relationship that we--too often we separate disability and health care into two separate components, and the two are, in my mind, in people's minds, unrelated. But there is a huge connection between your disability and your health care well being. So I appreciate that.

Mr. Atizado, one of the things that I take from this hearing is in this outreach the importance of making certain that veterans understand this is not just promoting community care. This is about promoting what is in the best interest of the veteran, that he or she, a decision he or she and their health care provider at the VA make, and the idea that we are not talking about that you are eligible. If we are not talking about that you are eligible for care to continue within the VA, without a referral outside that is a significant error on our part.

And I will work on my communication skills so that we make certain that the options are available, not to be decided by the person who is providing the information but by the veteran and his health care provider determining what is in their best interest, as the MISSION Act requires.

Senator Tester. Not to let you get the last word in,

but part of this--I mean, it is really a good point, and once again thanks for being here, the folks from the VA, because you could have a person that is scheduling these appointments, that says it is a hell of a lot easier to throw them in the community and then I really do not have to worry about them anymore. So this is really an important point to be addressing here today.

And so I just wanted, once again, Mr. Chairman, thank you for your good looks and your leadership.

Chairman Moran. You are using credibility.

[Laughter.]

Chairman Moran. And a point to follow that is Dr. Stone talking about incentives about referrals. That is, again, something I think is very important, the idea that budgetarily there may be an incentive to send somebody so that it is somebody else's problem, not how it gets paid.

I will conclude. I would ask the witnesses, is there anything that you want to make sure that is on the record? Do you want to say anything, correct anything, something that we failed to ask that would be of value to this hearing?

If not, we are going to conclude the hearing. Members have five days in which to submit additional statements or questions for the record, and we would appreciate your prompt response to those questions.

With that, the hearing is adjourned.

[Whereupon, at 11:59 a.m., the Committee was adjourned.]